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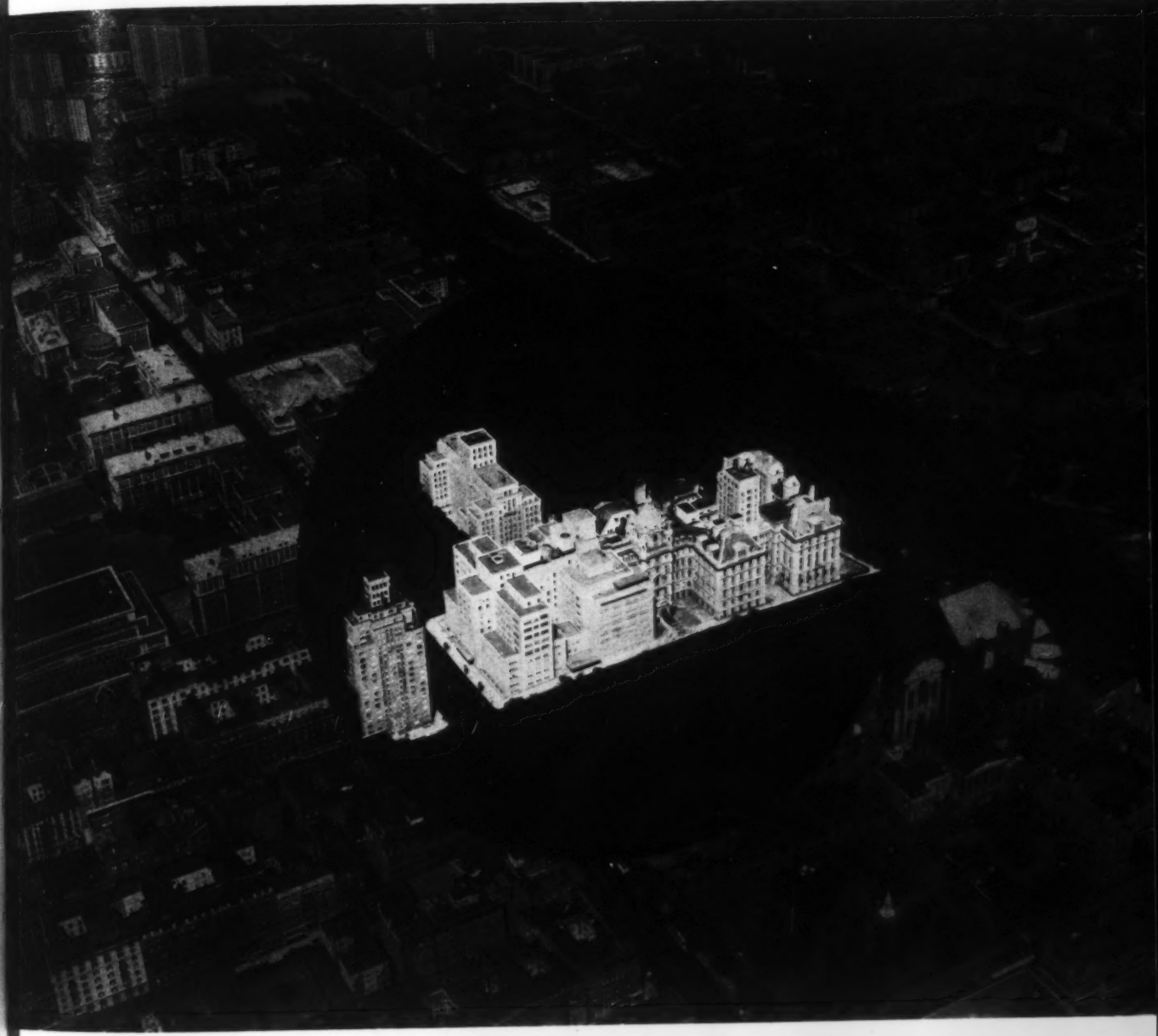

The Function of a Psychiatric Service in a General Hospital

see page 4

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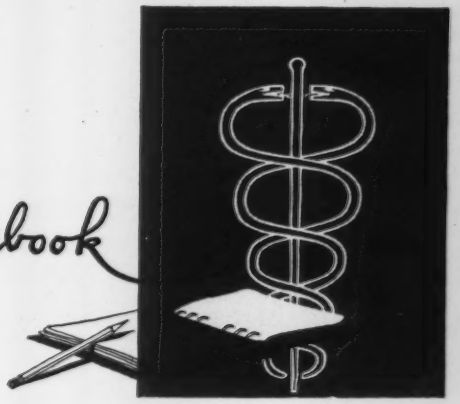
The Editor's Notebook



THE STAFF OF ANY PSYCHIATRIC FACILITY— public or private hospitals for the mentally ill or deficient, university centers, or mental clinics—must face the demands of medicine's inescapable trinity: treatment, research, and training. These are realistic demands which must be met for the common good. Yet, like an individual psychiatrist, a psychiatric insitution can easily defeat the very ends it seeks to accomplish. Imbalance of activities, treatment spread too thin, superficial teaching, and poorly-financed frenetic research can divert it from the reality of its missions. Its ultimate goal—more knowledge about mental illness—is no closer. The consequent and justifiable disappointment of the public will isolate this hospital, its patients and their caretakers. History could repeat itself; psychiatric hospitals could be rejected by society and become snake-pits again.

Relentless pressures for treatment will continue. Everyone has a potential for becoming mentally disturbed—children, adolescents, breadwinners, housewives, and grandparents. Escorted by anxious relatives they come to our clinics, our hospitals, our private waiting rooms. Eager for help, they are confident that they will receive it. Too often we crowd their names onto a waiting list or put them into an over-populated hospital ward.

We try to resolve our guilt feelings by all sorts of devices. We will treat only the very sickest patients, we say; or those with an acute disorder; or those who are the least sick and show the best chance of early recovery. What would we have lost if our colleagues in internal medicine, surgery, public health, pediatrics, etc., had elected to treat only the worst cases of malaria, gonorrhea, tuberculosis, and diphtheria, without regard for epidemiology? If they had not accepted their *total* responsibilities, we would not have mass immunization, preventive medicine, and vigorous public health departments.

Narrowing our treatment goals is not the answer. Instead we must face our responsibilities of meeting the actual needs of the public. We must understand that we face a massive public health problem and that without more knowledge, we can offer no hope of a smaller patient-load. We must accept the fact that the one-to-one relationship, historically basic to our specialty, is no longer adequate to meet all the needs.

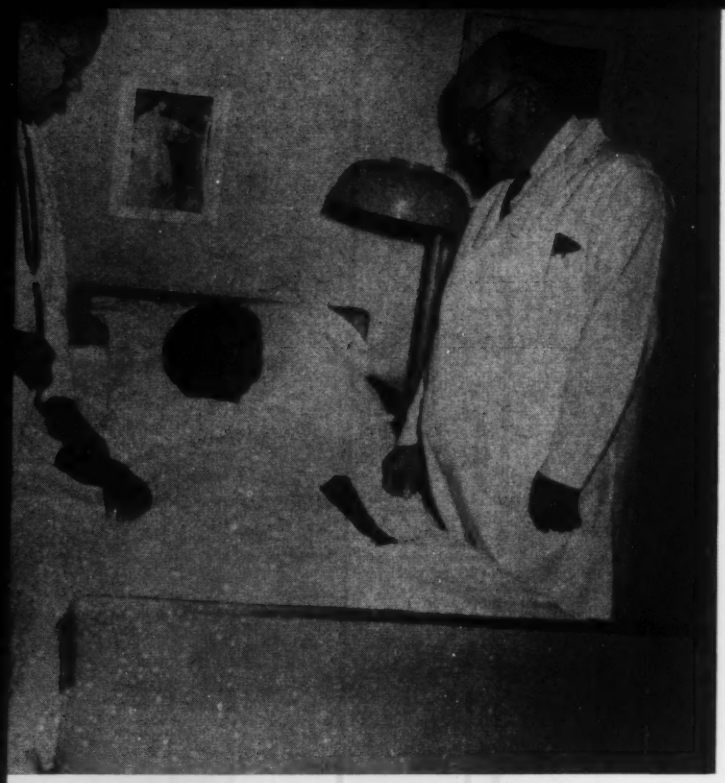
What can hospitals do in this seemingly insoluble dilemma? Some have already found workable techniques. Butler Hospital in Rhode Island, for instance, utilized traditional public relations techniques in conjunction with an integrated program of in- and outpatient services combined with day-hospital and home-service treatment, at the same time carrying out an active staff-training and research program. In Georgia, three general hospital units have been designated as facilities to which state-supported patients may be sent, thus keeping them close to their homes and at the same time affording early intensive treatment and follow-up service after discharge. In Washington, D. C., the District Branch has provided, with funds appropriated by Congress, an emergency psychiatric service for low-income patients, whereby private psychiatrists visit on a contract basis when an acute psychiatric emergency occurs. They refer the patient to a suitable facility. Boston State Hospital has recently initiated a similar program; a group from California reports on the first four months' operation of a psychiatric emergency service; New York City boasts of several experimental programs along similar lines.

As to increasing our public knowledge about problems of mental disorders, we must realize that there is not likely to be any one major "breakthrough." No one answer can fit all the questions. Psychiatric problems are too complex, their etiology too obscure, their nosology too indefinite. But each small item of information dredged up in the biochemical laboratory and the controlled-ward study, or evident in evaluated clinical results and investigations of family life and pressures, adds a little to our total picture—and temporarily to our immediate burden. Remember the great euphoric swell when the new drugs proved effective? Yet we quickly found that we needed more, not fewer, skilled professionals to consolidate the quickly achieved but fleeting gains.

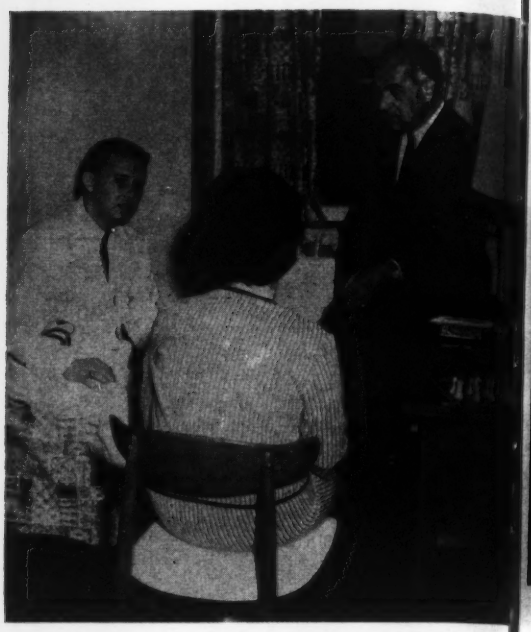
This brings us to the final major dimension of our responsibility—to seek a solution to the manpower crisis in our ranks by educating the coming generation of psychiatrists. And this is not all. We must spend enough time and effort in the training and developing of the paramedical specialists who play such an important part in the treatment of psychiatric illness. Unless we give more than lip service to this need, we run the risk of alienating ourselves from the very people we need so badly. As a corollary, some of our precious time must be devoted to continuing supervision, which is, after all, a form of post-graduate teaching.

The final report of the Joint Commission on Mental Illness and Health spells out some reasons why society rejects its mentally ill. I submit that this rejection is a social as well as an individual phenomenon which psychiatrists and psychiatric hospitals have helped to reinforce. Our deeds, not our words, are needed to break this pattern. Already a few imaginative and adventurous programs indicate the beginning of a trend which can bring us back into the market place to meet genuine psychiatric needs.

Matthew Ross, M.D.

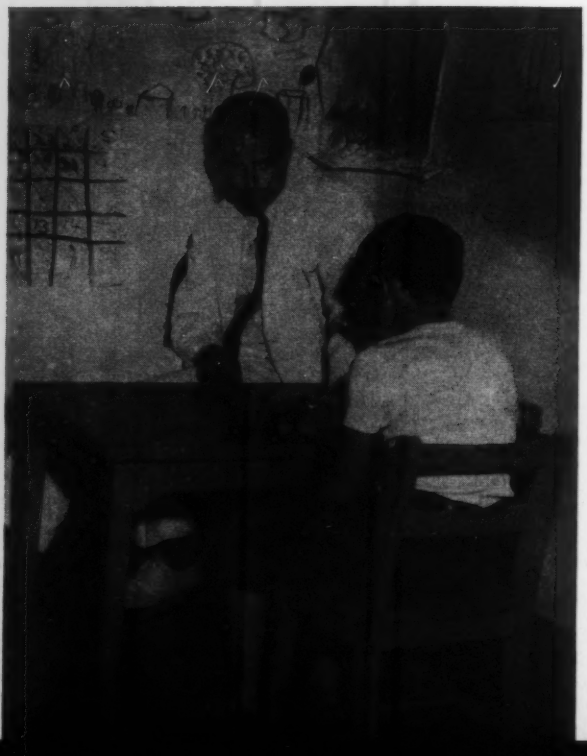


Dr. John M. Cotton talks with patient, as attending internist makes physical check after EST. Most accepted treatment modalities are used.



A resident interviews a patient; a senior psychiatrist on attending staff acts as his consultant.

The Function of a Psychiatric Service

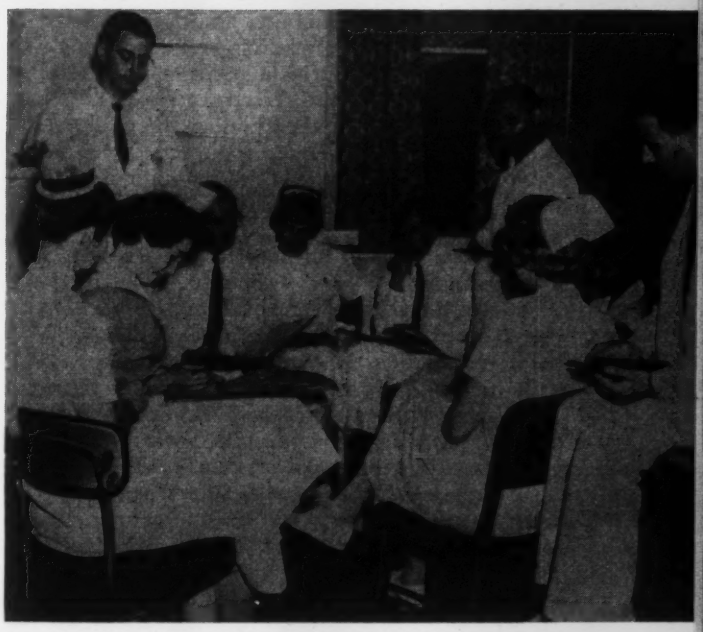


A cheerful chess game plays a part in treatment and training; the graduate nurse encourages the student.

The relaxed environment of the playroom is used for interviews with children visiting outpatient clinic.

No real patients are shown in these pictures. Hospital personnel acted as "models."

Working with clay is easier than remodeling a life pattern; the OT has a hand in both endeavors.



Attending psychiatrist holds daily staff meeting: residents, graduate and student nurses, aides, social workers, OT's usually come.

in a General Hospital

By JOHN M. COTTON, M.D.
Director, Department of Psychiatry
St. Luke's Hospital
New York, New York

ON JANUARY 1, 1955, Saint Luke's Hospital in New York City opened a complete psychiatric service that included a 29-bed inpatient unit. From the beginning the unit was closely integrated, structurally and functionally, with community services offered by our voluntary general hospital medical center. I would like to review this six-year experience and what it has meant in changing the pattern of patient-care, increasing the potential for training psychiatric and mental health personnel, and opening up opportunities for hospital participation in community preventive psychiatry and mental health efforts.

The psychiatric service includes inpatient and outpatient services, a children's clinic, and a department of community relations. Administrators of the service encourage research, and each division participates in training professional personnel.

Admissions are Acutely Ill Patients

The inpatient division, which is the principal one discussed in this paper, contains one-, two-, and four-bed rooms. Because of architectural difficulties, the entire floor is locked, but we have discovered that, ideally, two thirds of the division should be open and one-third locked. At the beginning, we made two arbitrary decisions that strongly influenced the whole operation. First, when the hospital administration granted us control of psychiatric admission, we established preference for acutely ill psychiatric patients whom we expected to respond to therapeutic techniques in a relatively short time. We have not violated our 90-day maximum treatment period more than six times in as many years. Second, we decided that not more than two thirds of the inpatients would be private patients. It would have been easy and financially rewarding to fill the beds with the private patients of our attending psychiatrists, but we believed that this would have compromised our resident training program and our obligations to our community.

Psychiatric Service Integrated with Others

Of course, psychiatric units in general hospitals are nothing new. Some of the oldest ones have been parts of general hospital teaching centers, but almost always they were attached to rather than integrated into the general hospital structure and function. Their organization generally followed that of the traditional, isolated asylum, with closed staffs who had little contact with the medical staff of the community.

At Saint Luke's, we have tried to make the psychi-

atric service as much like the other clinical services as possible. An open staff of attending psychiatrists may admit and care for their private patients; they also take regular turns of duty and directly supervise "service" patient-treatment and the training of residents. We do not have a separate record room; charts follow the established hospital form, with elaboration or deletion where necessary. Daily, all members of the staff enjoy close professional and social contact with colleagues in the other services. They freely request and receive consultations.

Obviously, we had to control admissions, so we established definite priorities. We always admit general hospital inpatients who develop emergency psychiatric conditions—even if we must put up an extra bed. Emergency psychiatric conditions affecting personnel of Columbia University or other closely related community agencies have highest priority. Our outpatients or those referred by educational, social, or religious institutions come next. The private patients of our attending staff have lowest priority. We do not admit alcoholic or addiction cases on a service basis, and accept chronic, recurrent mentally ill patients only when it is necessary to hold them until we can arrange for long-term treatment elsewhere. We frequently admit arteriosclerotic and senile patients for careful diagnostic study and a trial period of intensive treatment before we refer them for long-term care.

Attending and Nursing Staff Practices

Following the hospital's pattern, our service has three levels for attending staff: assistant, associate, and full-attending. At present, 29 attending staff members, beginning with clinic assistants, have courtesy privileges. Full-attending psychiatrists are members of the hospital's medical board; those who are beyond the mandatory retirement age continue their hospital association as consulting psychiatrists. All attending staff members, except consultants, must contribute six hours of professional service to the hospital each week in order to be recommended for annual reappointment.

The nursing department is the most important one in maintaining the high standard of patient-care in the inpatient division. It has 27 members—12 graduate nurses and 15 nurses' aides. The aides, who have proven their worth, must take formal on-the-job training and, when able to pass an examination, are promoted and receive pay comparable to that of a practical nurse. We treat these aides as professionals, and they participate regularly in morning rounds and staff conferences. Half of them have been with us from the beginning and are experienced, valuable members of the team, compensating in large measure for the very serious shortage of nurses.

We have the largest nursing staff for our patient-capacity in the entire hospital. This is necessary because: (1) 75 to 90 per cent of our patients are ambulatory, and the nursing staff's primary responsibility is to maintain a consistent milieu for them in accordance with the doctors' directions; and (2) we find it wise to discourage private nurses and do not allow them in the unit except to care for patients requiring extra attention because of serious physical illness. A nurse who is unfamiliar with our routines and methods can be more bother than help, and most private nurses who have had little or no experience with psychiatric patients quickly communicate their obvious anxiety or uncertainty to the patients.

Two social workers give valuable help in maintaining close contact with patients' homes and in manipulating troublesome social and domestic factors. A psychologist is available for psychometric testing. An occupational therapist completes our professional staff. The OT program is very useful, but we have altered standard techniques to meet the needs of short-term patients.

Factors mentioned above have influenced treatment methods which are most commonly used in our type of setting. Eight of our senior staff members are psychoanalysts, but classic analytic techniques obviously are not appropriate for our patients. We take special care during diagnostic studies to set long- and short-term goals. The residents receive consistent guidance in appropriate psychotherapeutic techniques for achieving short-term goals during the patient's hospitalization and for going on to long-term goals, after the patient's discharge, in the outpatient department.

Analysis of Diagnoses and Results

A large number of our patients suffer from acute depression and acute psychotic disorganization, and we still find that electroshock is the most reliable somatic treatment for 35 to 40 per cent of them. We have used all the drugs and therapies. Tranquilizers are genuinely helpful in many cases and are useful adjuncts to psychotherapy because they make it easier for patients to adjust to a strange environment and to accept the supportive psychotherapy so many of them need at first.

Between 1955 and 1961 we admitted 2,487 patients with the following diagnoses:

Schizophrenia	31%
Psychoneurosis	24%
Depressive Reactions	21%
Chronic Brain Syndrome	10%
Personality Disorders (including alcohol and addiction)	5%
Acute Brain Syndrome	6%
Without mental disorder	3%

The percentage of depressive reactions may seem low for an acute service, but we list psychoneurotic depressions and reactive depressions under psychoneurosis. We include schizo-affective disorders under schizophrenia. We made the interesting discovery that more than 10 per cent of our patients had a primary somatic illness, although their admission diagnoses were primarily psychiatric. Our rich variety of diagnostic problems offers stimulating training opportu-

nities for residents—obscure brain tumors, a variety of metabolic disturbances and, recently, a woman in an acutely confused state (diagnosed as psychiatric by her physician) who actually had serious electrolyte imbalances secondary to a fecal impaction and partial obstruction.

The following condensed table indicates the results of our operation:

Patients admitted per year	450
Average length of stay	20 days
Per cent of bed-occupancy	85%
Disposition	
Returned to community	87%
Transferred to other hospitals	8%
Transferred to other services	4%
Deaths	1%

These startling figures show that we are treating psychiatric patients for less than three weeks and returning 87 per cent to their homes. Admittedly, our policy of limiting admissions to acute illnesses has something to do with these results. But more important to our success is the atmosphere of enthusiastic optimism that pervades the ward. We emphasize to each patient that his illness is treatable and that his absence from the community is temporary. Perhaps, long hospitalization—so often considered necessary in the past—removed the patient from his community, his job, and his home so successfully that it subtly interfered with his motivation for recovery and discharge.

Analogy with Military Psychiatry

We do not believe that we have *cured* these patients in 20 days and we follow them after discharge for varying periods—sometimes for many months. But we do think our results indicate that prolonged hospital care is unnecessary for many psychiatric patients, especially in hospitals that strive to return the patient to his community as soon as possible and provide adequate facilities for outpatient follow-up.

During World War II, less than 5 per cent of the psychiatric combat casualties evacuated to the rear echelons returned to full duty. The general policy was to evacuate these cases to the interior for definitive treatment. The patient's loss of contact with his unit, where his strongest loyalties and feelings of personal obligation were rooted, so undermined motivations for return to combat that few of the men recovered sufficiently to go back. All types of treatment failed when used at centers far removed from the unit.

The efforts of Drs. Roy Grinker, Frederick Hanson, and Douglas Kelley[1] demonstrate that the simplest techniques of sedation and ventilation were effective when used promptly in a setting close to the patients' combat organization. In the Korean War, Colonel Albert Glass[2] established small centers for intensive psychiatric treatment in front of regimental aid stations which had direct contact with the combat units; the rate of stable return to full duty was consistently better than 70 per cent.

Of course, our problems are quite different in a community psychiatric facility, but there is, perhaps, an analogy. We realize that many patients with severe, deeply rooted psychiatric illnesses will continue to require long-term treatment in special centers. We also believe that some of these patients can be kept functioning on a reduced but useful level when treated in their home communities. We are convinced that the less severe reversible psychiatric illnesses are spared much morbidity by being treated early and in the patient's own community; financially and in terms of morale, the savings for the patient and community are very great.

Residency Program Augmented

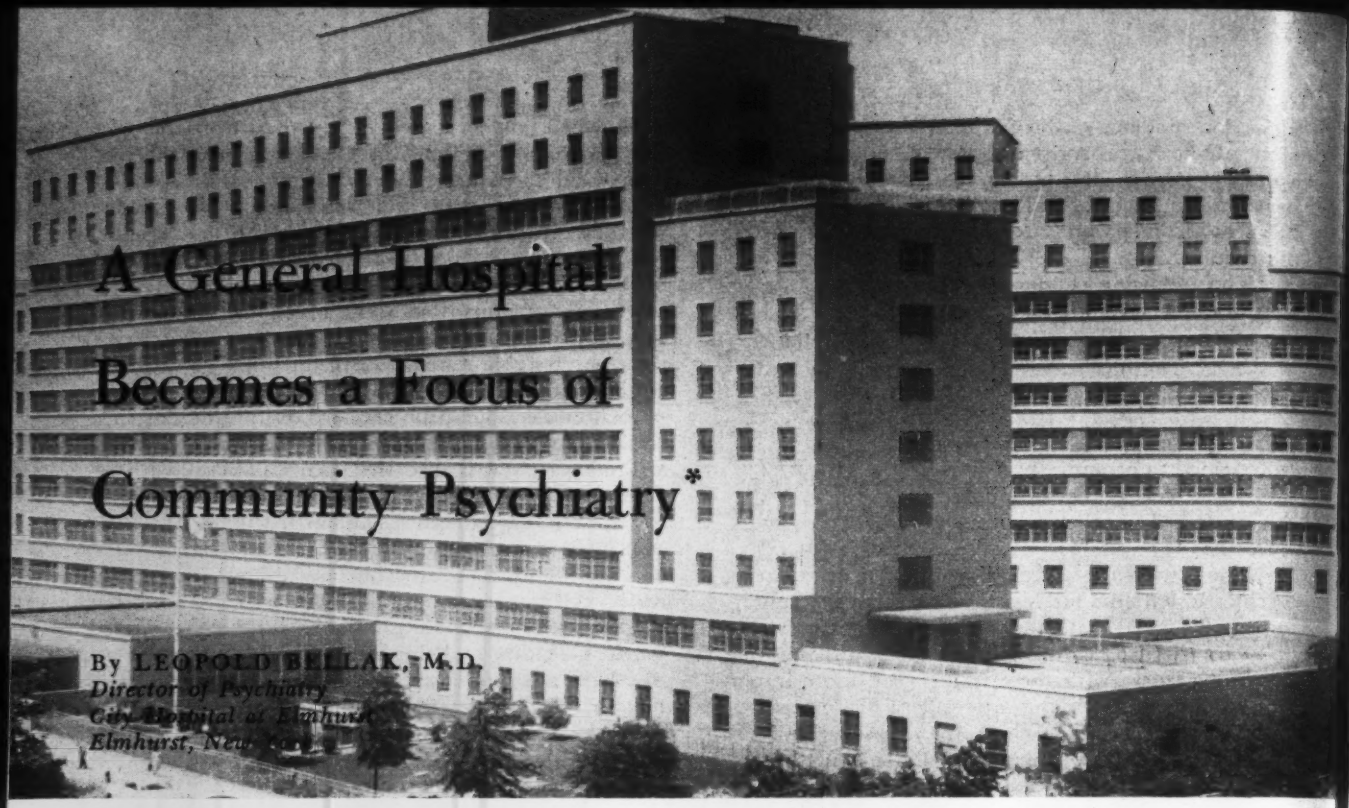
Saint Luke's inpatient psychiatric unit offers a full three-year program in resident training. The rich and varied clinical material, the opportunities to consistently supervise patients in and out of the hospital for long periods, the possibility for further experience in the children's service and community service clinic, and the close contact with other medical specialties in an active teaching hospital all contribute to a busy and rewarding program. However, we have felt that this is not enough, principally because of lack of contact with chronic psychiatric illness. Therefore, we have arranged for residents to spend almost a full year of the training period in affiliated teaching institutions that afford first-hand experience in and knowledge of chronic mental illness.

We believe that the integrated psychiatric service in a general hospital is a valuable new health resource. It does not replace present psychiatric facilities, but as an adjunct, makes a valuable contribution to the community and to the patient in offering early aggressive treatment for the mentally ill *near their homes.* It certainly should be a helpful new instrument in combatting the staggering and growing problem of psychiatric morbidity in this country. •

---

[1]*Dr. Grinker, chairman of the Department of Neurology and Psychiatry at Michael Reese Hospital, Chicago, Ill., served in the U. S. Army Air Force, 1942-46, and was author (with J. Spiegel) of Men Under Stress. Dr. Hanson, who was with both the Canadian and the U. S. Army Medical Corps, 1939-46, is author of Bulletin 2 on Combat Psychiatry. He is now in private practice in New York and also is Consultant to the Surgeon General, U. S. Army. Dr. Kelley, now deceased, was with the U. S. Army Medical Department, 1942-47, and was active in the European Theater and later at the Nuremburg trials.*

[2]*Colonel Glass has written a number of articles on combat psychiatry and has held several posts as psychiatrist or consultant in the U. S. Armed Forces. Currently, he is Consultant in Psychiatry in the Office of the Surgeon General of the U.S. Army.*



A General Hospital Becomes a Focus of Community Psychiatry*

By LEOPOLD BELLAK, M.D.
Director of Psychiatry
City Hospital at Elmhurst
Elmhurst, New York

PSYCHIATRY IS NOT ONLY A BASIC MEDICAL SCIENCE and a field of therapeutics, but also a proper branch of public health and preventive medicine. In this frame of reference, it is only natural for general hospitals to serve their communities by becoming nodal points of preventive medicine and public health functions in psychiatry. That is why we set up our Comprehensive Community Psychiatric Program at City Hospital to reach key community figures and make them more aware of psychiatric problems and how to deal with them.

City Hospital is a general hospital of 1,000 beds. The psychiatric department has 145 beds, 12 full-time staff psychiatrists, 15 residents, 10 full-time psychologists, six social workers, recreational personnel, etc. At present, the active components of our community psychiatric program include a Trouble Shooting Clinic and separate psychiatric seminars for general practitioners, chaplains, guidance teachers, and lawyers.

• *The Trouble Shooting Clinic*—I initiated this clinic in October 1958. It is supervised by David Lehine, M.D., and designed to offer first-aid to persons suffering from emotional problems. However, unlike the ordinary emergency room, it is not limited to urgent crises; we encourage its use as a counseling center.

We want to teach our population that to deal with more or less minor disturbances is often the soundest way to avert potentially serious difficulties. We constantly observe how unrealistic laymen's notions are of physical illness, legal problems, marital relations, and any number of relatively superficial tensions and anxieties. We want people to know that there is a place where they can receive competent information about these things. The Trouble Shooting Clinic is such a place; anyone may walk in and simply talk things over. The clinic offers on-the-spot treatment for troubled feelings caused by the vexing, ordinary problems of everyday life.

At first, the clinic was open only two evenings and one morning a week, but now operates 24 hours a day. Except for emergencies, it serves only the indigent.

Intake Psychiatrist Makes Appropriate Referrals

A full-time staff psychiatrist acts as intake officer for all patients who come to our Mental Hygiene Clinic (of which the Trouble Shooting Clinic is a special but integral part). He records his immediate impressions of the patient and makes suggestions for handling the case. He may refer the patient to the Trouble Shooting Clinic, to the regular Outpatient Clinic for longer treatment, to the Inpatient Service or other medical clinics for further diagnosis, to the clinic psychologist, or to a social worker for case work or direction to other services.

If the intake officer thinks that the patient will

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Psychologists give diagnostic tests (above) in inpatient and outpatient services; they also take part in seminars for GP's.

be able to cope with his problem after a maximum of three to five visits, he refers the patient to the Trouble Shooting Clinic where the staff has been trained in special techniques for giving brief psychotherapy. Therapy varies widely—all the way from judicious "cathartic" drive-content interpretations to modifications of defense or manipulation of environmental circumstances. The approach is flexible and determined solely by what will be most constructive and most likely to lead to a quick and better re-structuring of patient and situation.

To date, the Trouble Shooting Clinic, which has handled over 3,000 cases, has been successful in finding acceptance and usefully serving the community.

• *The Psychiatric Seminar for General Practitioners* —This is supported by a U.S. Public Health Service grant, and directed by me. Twenty-two general practitioners are currently participating in the second course. It is a well-established fact that patients consult the GP for latent emotional difficulties almost as often as they do for physical symptoms. Therefore, the physician is often the first to have the opportunity of recognizing a psychiatric disturbance. Since he is in a position to prevent such disturbances from getting out-of-hand, he should be one of the first lines of defense against mental illness. Our seminar endeavors to help the GP function with greater psychiatric understanding by acquainting him with basic concepts and methods of dealing with some of the psychiatric aspects of physical illness.

A staff social worker familiarizes the participating physicians with community resources. The chief psychologist introduces them to psychological diagnostic work. Finally, we permit interested and particularly well-suited doctors to observe and then to practice supervised brief psychotherapy in the clinic. The object of this experience is to further sensitize the GP to the psychodynamic process in patients.

GP Receives Practical Experience

Together, a staff psychiatrist and GP trainee see a new patient in the Trouble Shooting Clinic. The psychiatrist does the interviewing; the trainee listens. If the psychiatrist thinks that the patient is suitable for further therapy by the trainee, he lets the latter conduct the second interview, but remains present himself. At the third session and thereafter, the GP conducts the interviews alone. (For the purpose of the training program, patients are seen more often than the usual three to five times.) The trainee reports his interviews later to the staff psychiatrist.

This method of supervised psychotherapy is quite reliable because the psychiatrist has first-hand knowledge of the patient; it permits the trainee to observe the initial steps and the supervisor to participate in the trainee's first venture. The trainee may be as old, if not older, than the staff psychiatrist, and the patient is not apt to feel that he has been turned over to a junior therapist.

Naturally, the course also includes discussions about tranquilizers, problems of psychiatric diagnosis, hypnosis, and a wide variety of other topics.

• *The Psychiatric Seminar for Chaplains*—A number of ministers, priests, and rabbis attend this seminar which is directed by Ernest Hammerschag, M.D., and Gabriel DelaVega, M.D. Since some of the participating chaplains are attached to the Department of Hospitals, the seminar has led to increased use of their resources in the therapeutic management of medicosurgical patients as well as psychiatric ones. One of our main objectives is to help the chaplain recognize and differentiate between a person's psychiatric and religous problems and to encourage a visit to the psychiatrist when indicated.

• *The Teachers' Consultation Service*—Communities and schools urgently need more extensive psychiatric services for handling the problems of children. This motivated us to organize the teachers' service which is supervised by Alexander Schusdek, M.D. The aim of the service is to make school personnel more perceptive, psychiatrically, and more effective in utilizing the community's resources.

Frequently, psychiatric referrals coming through the school system are inappropriate or inadequate—student or parent is insufficiently prepared for the referral, or the school has not obtained significant information. Indeed, in many instances, the referral should not be made at all. We believe that a more

psychiatrically alert school personnel might be instrumental in spotting embryonic disturbances, the serious nature of which might not otherwise become manifest for many years.

In our seminar, one guidance teacher presents the problem of a particular student each week. The student's classroom teachers also attend the meeting. The entire group participates in the discussion, which broadens their psychiatric knowledge and understanding.

• *The Seminar for Lawyers*—We originated this seminar, which is directed by Milton Malev, M.D., because many matters brought to an attorney's attention have emotional or psychiatric undertones. The sound settlement of many seemingly cut-and-dried legal problems require a great deal of psychological understanding. In divorce, for instance, arrangements all too often fail to include cognizance of children's current and future emotional needs. The practice of criminal law involves many serious psychiatric considerations. We believe that the attorney can function best when, psychologically, he understands the case in point and the quality of his emotional relationship with his client.

These, then, are some of our means of reaching out into the community. In addition, we are working out plans for a routine psychiatric examination of children because early recognition of emotional turmoil frequently arrests a more serious condition. We hope to develop a technique that will be brief enough to be included in regular pediatric checkups. This will not be easy. Such an examination must include family diagnosis and, sometimes, family involvement in treatment plans or actual treatment in order to avoid or abort incipient psychiatric problems.

Projected Service for Parents

It seems reasonable to us that psychiatric consultation during the earliest pathological parent-child interactions could become a valuable instrument in screening and handling mental disorders. These consultations also could provide the groundwork for a long-term longitudinal study of both normal and pathological child-parent interrelations and developmental problems.

Although it is not yet underway, the over-all plan for our School for Parents is well-defined. It will have two distinct parts. The first, essentially didactic, will consist of courses in basic information concerning the emotional development of children at different age levels. The second will be round-table discussions of group-therapeutic structure in which parents can express some of their own problems. We will group parents together who have children of comparable ages. When we discover parents whose children need special attention, we will refer the children for individual care.

In order to bring psychiatry to the *hospital* community, we have a staff psychiatrist who acts as liaison officer to all other services in the hospital. He is available for consultations and presents psychiatric viewpoints when they are necessary in the management of various patients with medicosurgical problems. We hope that soon every hospital which is big enough to have a medical-surgical emergency clinic will have *at least* one psychiatrist available to deal with emotional emergencies as well.

We are also operating a Psychiatric Consultation Center for physicians, directed by Stanley Brodsky, M.D. It functions like a clinical conference. At each weekly meeting, one or more physicians present for consultation the psychiatric and emotional aspects of current cases. For example, discussion might center on emotional problems and implications of long-term treatment in an orthopedic case, the emotional aspects of a cataract removal, or the intractable intestinal pains of a menopausal woman. The conferences are flexible so that physicians may attend every meeting or choose to drop in on those which interest them most.

These projects are the main parts of our Comprehensive Community Psychiatric Program. But we also have a continuing interest in the rehabilitation and reintegration of hospital-discharged patients when they return to the community.

Various Other Service Plans

We are in the process of organizing a variety of other services. One will be a psychiatric seminar for all kinds of hospital employees, including reception desk clerks. Stanley Schulman, the hospital's assistant administrator, suggested this program after he overheard a receptionist ask an inquiring relative, "Was he discharged or did he die?" Such a remark does not contribute to the ease of relatives or patients, and we believe that even elevator operators need to be aware of the effect they can have on the total atmosphere of the hospital.

Alonzo J. Beavers, M.D., former director of our Trouble Shooting Clinic and now associate director of the hospital, orginated another service idea. He has suggested that we have a psychiatric seminar for detectives and policemen, similar to the seminars for teachers and chaplains. It would deal with psychiatric aspects and understanding of daily problems, emphasizing the law enforcement officer's own problems in simultaneously representing authority and the public servant.

The psychiatric arm of any hospital assumes a sociological function in our world of "lonely crowds." Our Trouble Shooting Clinic and the key figures in our community who have acquired some psychodynamic understanding can often perform the functions of friend, neighbor, family doctor, or even of the closely knit family that is disappearing in our swiftly changing technological society. We hope that the clinic and our other programs will suggest ways for the psychiatric departments of many more general hospitals to serve the community as the much-needed foci in preventing and curing mental illness. •

V. Despite Fragmentation of Psychiatry and Unscientific Approaches to Research, all Hospitals can Glean Vital Information through Patient-focused Investigations.

Psychiatry at the Crossroads

By JOHN W. LOVETT DOUST, M.B., MRCP (London), FRCP (C)
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EMIL KRAEPELIN FOUNDED the world's first Research Institute of Psychiatry, the Forschungsanstalt of Munich in 1920, when alienists were concerned with simple custodial care of a relatively small segment of the population. Today the psychiatrist is hard put to control the colossus of psychological medicine organized to meet the needs of thousands of patients. Yet he is no empire builder.

The diversification of the psychiatrist's clinical interests, inside as well as outside the newly unlocked doors of mental hospitals, has been forced upon him by the demands of society. He finds himself involved in politics, in cold-war strategy and hot-war tactics, in the speculations of philosophers, in industry and advertising, in space-age medicine, and in the psychophysical relations of general medicine. His "basic sciences" of psychology, neurology, and neuropathology have expanded to include sociology, anthropology, ecology, biochemical as well as epidemiological genetics, neuro- and psychophysiology, pharmacology, biochemistry, and a host of others.

Today's Psychiatrist—All-Purpose Expert?

Almost all the life sciences and philosophies concerning human and animal mind-body interrelationships are deemed proper to the psychiatrist's expertise —even the relationship between man and the universe, now that religion has been forced into the bandwagon of progress! (25,7) By some adaptation of Parkinson's law, the horizons of psychiatry, if not of the individual psychiatrist, have been so extended and refracted that today's young psychiatrist sees a mirage of competence, concern, and acceptance in regard to these disciplines.

The late E. B. Straus of London used to tell his medical students, "Psychiatry is the other half of medicine." Perhaps the great broadening of psychiatric interests is but a reflection of the mid-century expansion of scientific and especially medical scientific knowledge. The internist has moved away from the bedside and into the laboratory, implicitly assuming that now all the syndromes have been adequately described. In psychological medicine, too, the era of prolific syndrome description is past. It seems to have been replaced by a nosophobia as frustrating to scientific classification as it is confusing to our colleagues.

Divorcement of Psychiatry from Medicine

Modern psychiatry is accustomed to change. After a centuries-long Age of Apprehension, Esquirol led our specialty into an Age of Humanitarianism, which, at the turn of the century, was replaced by an Age of Adventure. Psychiatry then entered the Age of Analysis, and today seems to be hurling itself with terrifying momentum into an Age of Despair. Until recently, the psychiatrist could at least feel secure in his claim to medical kinship with other colleagues in the experience and practice of medicine. But today psychiatry has robbed itself of scientific authority because its practitioners have failed to meet the criteria of agreement necessary for validation, reliability, and accurate prediction and expectation. It is burdened by splinter schools of thought, each clamoring for recognition as the exclusive possessor of truth. It is embattled and challenged by charlatans and mystics, eschewed by other medical fields as obscurantist and unintelligible, and feared and rejected by the man in the street.

**This paper is one of a series sponsored by the Program Committee for the 13th Mental Hospital Institute. The Institute discussions are to be based upon Action for Mental Health, the final report of the Joint Commission on Mental Illness and Health, which contains important recommendations on research.*

Seemingly, we have failed to reckon with the erosion of our specialty by our paramedical colleagues and with the growing dissatisfaction and disharmony within our own ranks.

Recently Michael Balint (5) drew a distinction between "scientific or hospital medicine" and "the other kind of medicine" which is to attempt "not so much diagnosis in precision as diagnosis in depth." Its criteria would be "whole person pathology" and its main task "to understand the meaning for the person of the complaints and illnesses that he offers to his doctor." The aim of its (psycho) therapy will be "to enable the patient better to understand himself."

Derogation of psychiatry to second-class medicine is a sufficient blow, but it is a minor contusion compared with an attempted mortal wound recently inflicted by another psychoanalyist, Thomas Szasz (26), who enters the joust with a relentless attack on the medical basis and framework of psychiatry. He systematically destroys what he regards as the shibboleths of the pseudomedical traditions of psychiatry, pleading that psychotherapy is designed to help people learn about themselves and about life in general—not to recover from an illness. Psychiatry and its tools, Szasz claims, have as little relation to scientific medicine as mental illness has to a "disease process."

These attacks come hard upon a systematic if specious attempt by Kruse (18) to show that there is more agreement than otherwise between the life sciences (both medical and paramedical) and psychiatry and the problems of mental illness, plus an argument by Engel (14) that grief has all the medical characteristics of a disease and should, therefore, be considered *sui generis* as such. Together, these arguments throw light upon the nature of the controversy raging around the meaning of psychiatry and its responsibilities within or without medical science. Even the education of medical students and psychiatric trainees has felt the impact, as illustrated by two recent appointments of an anthropologist in Great Britain and a physiologist in the U. S. to chairs of psychiatry in university departments.

What Becomes of Scientific Realism?

During a jeremiad before the Third World Congress of Psychiatry, Jules Masserman (20) claimed that few significant advances have been made either in better understanding or in treating psychiatric patients. In his view "no one has demonstrated that any other method can in the long run surpass Esquirol's humane treatment at Bicêtre which cured one third and improved another third" of the patients. Current therapies, he claimed, have little lasting effect and only slightly augment spontaneous recovery rates.

If we agree with Masserman's further claims that "man's fundamental terrors are abhorrence of physical injury and death, uncertainty as to the reliability of his alliances with his fellows, and fear that he may be little more than a cosmic triviality" we may also be tempted to commend the tripartite role he postulates for the physician: the medical scientist who will explore and treat physical ills; the parent who will comfort the frightened, appealing child; and the "ordained wizard" who will mediate comfort through magic. He pleaded for rapprochement of psychiatry, sociology, and religion against the background of the Golden Rule, and a respect for the conservation of "serenity guaranteed man by his beliefs in his own future divinity among his many-visaged gods."

Equally scientifically nihilistic are the comments of Arthur Koestler (17), an acute lay-observer. He quickly dismissed Pavlov: "A fanatical but influential minority of diehards, trapped in the superstitions of the past, still insist on treating man as a conditioned reflex automaton, and knowledge as the accretion of lucky guesses—a fair description, perhaps, of how behaviorist minds work, applied by faulty generalization to humanity at large. But they are the rearguard entrenched in the groves of academe, heroically defending a lost cause, like the Swiss Guard dying on the staircase of the Tuileries."

Commenting on the remarks of the many distinguished participants in the symposium on the body-mind relationship, Koestler pointed up the paradox that the neuro-anatomists, physiologists, neuropathologists, and neurosurgeons "whom one would have expected to take a materialistic view, all took the opposite attitude . . . (brain is brain and mind is mind and we don't know how the twain meet); whereas the logicians, whom one would have expected to show some respect for the mind, showed none at all and seemed hypnotized by neural pathways and electrical circuitry." He quoted Penfield as saying "when it comes to the problem of how the mind is attached to the body, we are no wiser today than Aristotle was when he asked that question 2,300 years ago."

Over-enthusiasm Helps Fragment Psychiatry

To Koestler, the confluent trends of neurophysiology, neuropharmacology, experimental psychology, and psychotherapy indicate "that we all live in a kind of psychomagnetic world, saturated with energies that interact on an unconscious level, vulnerable to voodoos and love-philtre placebos . . . We are once more plunged into the magic world . . . and thereby hangs a new tale, the dawn of a new era in the study of the human psyche."

How have we arrived at these haphazard fragmentations of our specialty? One route has obviously been the immense overlap which exists between the mind and its disorders, and almost every aspect of the physical world (including the body) through which it commands expression; a corollary of this is the apparent but not real impossibility of investigating a concept known only by its effects. The earlier studies of viruses afford an oversimplified analogy. Other routes have been the complex byways of the subject and the difficulty of controlling all the variables involved, and the exclusively human qualities of most types of mental breakdown, which preclude animal involvement

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Mead Johnson Laboratories

Symbol of service in medicine

except in the most gross types of experimentation. Perhaps the most compelling and insidious route has been the enthusiasm of psychiatry's paramedical scientific colleagues.

We might take consolation from the fact that if psychiatry seems to be disintegrating under the series of scientific attacks by physiology, biochemistry, psychology, and the social sciences, it is keeping good company! Recently, the chairman of Washington University's Committee on Molecular Biology felt impelled to defend, before the American Association for the Advancement of Science (10) the very existence of biology itself. As with psychiatry, the attack on biology comes as much from the Judas within as from parabiologic sources. Commoner quotes a reviewer (23) of Asimov's new book (4) about modern biology; "For him . . . biology is a system that proceeds from biochemistry to the associated subjects of neurophysiology and genetics. All else, as they used to say of the nonphysical sciences, is stamp collecting." Asimov puts it quite bluntly in his opening paragraph: "Modern science has all but wiped out the borderline between life and non-life," and later (p. 535), "All the substances of living matter—enzymes and all the others, whose production is catalyzed by enzymes—depend, in the last analysis, on DNA." As Commoner bitterly commented, if Asimov's claim is "even remotely correct, biology is not under attack; it has been annihilated."

Over the past few years, there has been a plethora of articles and conferences summarizing the fields and scope of psychiatric research. There are those who have been frankly critical of the directions psychiatry has been taking and scornful of the potential of current research. There are those who ploddingly enumerate a series of advances against a general background of psychobiology (12) stressing the dynamic psychopathological basis of psychiatric investigation and pleading for the development of new techniques and more accurate knowledge. And there are those who recognize that we shall make few gains unless we take time out to attempt an evaluation of where we are heading.

Experimental Boundaries Seem Unlimited

A recent Pittsburgh conference on experimental psychiatry (8) suggested models for testing psychoanalytic formulations (2); made a theoretical attempt to construct a unified theory of human behavior, using anxiety as a variable common to its psychological, biological, and social aspects (16); and gave an historical account of the Freud-Pavlov controversy, followed by a description of experiments on the effects of isolation on conditionability in sheep and goats (19), and another on the adaptive behavior of the Rhesus monkey after hemicerebrectomy (22). The remaining 13 papers presented at the conference were reflections of such topics as "the architecture of knowledge," "the nature of discovery," "the shape of research," possible new approaches in the "strategy" of research, and so on. All were fascinating and their range was vast, extending from the "calibration of linguistic tools in psychopharmacology" (13), through Gerty's (15) conviction that "mediocrity and imagination do not like to keep company," to McCulloch's (21) questions: ". . . where is fancy bred? Or in the heart or in the head? How begot, how nourished?"—questions only he could pose and which he answered by an Odyssey on communication and cybernetic theory, a lyrical appeal for nuclear disarmament, and a Shakespearean sonnet. Ten years ago, even Desmond Curran would not have believed that psychiatry could be so unlimited!

Not long ago, I had the opportunity to analyze the research applications for Canadian Federal-Provincial Mental Health Grants. Some 96 applications were processed, and a breakdown of the aims, orientations, and disciplines involved suggested that about two thirds of the investigations stemmed from the basic sciences of psychiatry and the remaining third from clinical procedures. These proportions are probably not too disparate from comparable figures elsewhere.

If massive governmental support of psychiatric research is to be sought and fruitfully utilized, the previous pedestrian and overpatterned approach must be abandoned. Many people during the past decade have made this plea (e.g. Ruesch, 1957 (24)). Certainly Ernest Allen's list of criteria, used by the National Institute of Health (3) to judge applications, would have excluded many of the contributions to experimental psychiatry discussed during the Pittsburgh conference. As Bjorksten (6) commented, similar criteria in the past would automatically have excluded from support Harvey's discovery of the circulation of the blood, von Haller's concept of nerve irritability, Beaumont's studies on human gastric friction, Lavoisier's combustion studies, and Pasteur's work on vaccines. Bjorksten's examples are particularly relevant to our purpose since more than one of these men made their contribution to science and discovery outside the fields of their individual training and experience.

As never before, psychiatry faces a time of decision. Previously the Cinderella of medicine, her favors today are being sought by many vigorous young suitors, and the choice she will make may well alter the course of history. There is no time for indecision. The mental hospital is undergoing a transformation and moving out into the community; mental health clinics, outpatient departments, day-care centers and night hospitals, and psychiatric units in general hospitals are being accepted by the public in a way scarcely envisaged before World War II. Smaller hospitals in urban areas alongside general hospitals as recommended in Canada's Tyhurst Report and Ontario's Mental Health Program are already coming into being. As education advances, and awareness and acceptance of psychiatric problems increase, the winds of change are whipping up a tide of public demand which threatens the native conservatism of the psychiatrist, and poses a challenge which he must meet.

Personal Views of Possible Directions

In the teeth of so much conflicting evidence, I can only offer my personal views as to how psychiatric research should be oriented for the future. The following points seem relevant:

First, to divorce psychiatry from medicine is to invite the doom of scientific development in the field of mental illness. Work on psychosomatic interrelationships has been directed toward an elucidation of an age-old philosophical problem and the psychiatric education of internists. Psychiatry must acknowledge and pay tribute to its medical parentage for the sake of its own continued development as well as for the benefit of medicine as a whole.

Second, many of the disputes among psychiatric researchers can be attributed to the varying nature of the problems they are investigating. These disagreements were aired during the Third World Congress of Psychiatry. A growing opinion, expressed especially by European participants, was that psychiatry has to deal with two essentially different types of patients: the psychotics, largely found in mental hospital populations, whose paradigm is schizophrenia, and whose sickness is the result of a disease process ultimately to be explained biologically; and the neurotics, largely seen in outpatient settings, whose paradigm is anxiety-hysteria, and whose sickness is a reaction formation of character development in response to psychologically symbolized stressors from the environment. By this method of distinction, psychiatric problems can be separated for inquiry into questions of interest to neurophysiologists, biochemists, geneticists, and other biologists; and those of more concern to psychologists, sociologists, and other behavioral scientists. While this dichotomy of patient-groups may be theoretically unacceptable to North American psychiatrists, in practice it is not a Procrustean bed, and its explicit acknowledgment would help to resolve some of the disagreements we have been discussing.

All Investigations Need Patient-Focus

Third, psychiatry is a specialty of clinical medicine. Because of this, investigations should ideally be centered on patients. Biochemical laboratories work on pooled urines obtained from 40 or 50 patients with "schizophrenia" in an endeavor to identify some unusual or suspectedly toxic product; the behavioral scientists ask groups of 100 or more "neurotics" to perform a learning theory task or to fill out questionnaires. We must deplore such inquiries when they are made in the absence of detailed information on each patient concerned and unless a competent psychiatrist is available to direct and integrate such research. This is not to imply that the interest and efforts of the paramedical disciplines should be discouraged; we need all we can get. But it does imply that this interest should not be confined to an isolated university department and that the efforts should be geared to psychiatric perception of the problems being investigated.

A fourth point concerns the possibility of carrying out research within the mental hospital. Unwieldy as many such hospitals are, some of them have managed to carry out much original and valuable work. There are a number of obvious ways in which large public hospitals can be "rehabilitated" in their research function, and thus their creeping isolation halted. Most psychiatric hospitals could establish an investigation unit of some 12 to 20 beds and, for directors of psychiatric research, create senior posts which carry status, tenure, and salary at least equal to those of medical superintendents. A moiety of these hospitals can be linked with a university department of psychiatry, and legislators can be persuaded to allocate public funds for research purposes. •

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Dead Hands of the Past

By DR. WHATSISNAME

IN ITS REPORT number 46, the Group for the Advancement of Psychiatry points out that "mental hospitals sometimes have goals and policies that were framed by people long since dead." Thus, in a real sense, our hospitals are mortgaged; that is, they the under the weight of a "dead pledge"—*mort gage*. In the business world, a mortgage is an obligation that survives the man who made it, and the mortgaged property often is encumbered by this obligation for many years.

Most of our mental hospital buildings were designed by architects, now dead, from suggestions made by superintendents, legislators, and commissioners—all dead, too. The long hospital stay of some patients and the high ratio of seniles among the new patients conspire to reconfirm this necrotic aura.

Experience carries its own wisdom and certainly there is some validity to the thought that "this has always worked well, so why change it for something untried?" But such placid respect is not always practical. The typical public hospital has a record room full of printed forms, adopted decades ago, that now carry obsolete words and phrases. There still are rule books which say that men patients and employees may smoke, but that women may not. Visiting hours and visiting rules are often relics of the days when trains and trolleys were needed to get a relative to the hospital.

These quaint residues of grandfather's day make many superintendents hesitate to initiate change because—almost superstitiously—they dread possible but usually improbable reactions. Abolishing an apparently useless report form, for example, *might* result in unexpected disorder. Expanding visiting days and hours *could* affect the staffing of wards and even the policing of parking lots. Some superintendents have done away with old requirements only to let an acute flurry of chain-reaction results force them to reinstate the undesirable. It is not unusual for young clinical directors to rely on the statement, "I guess the old fellows knew what they were doing after all."

This leads to a form of ancestor worship. It is almost as if the staff believes that any change will be an insult to a departed father figure. There is strange irony here: psychiatrists sometimes develop anxiety about challenging the long-dead father figure, but businessmen—to whom "modern" is a word of praise—delight in slaying it. Maybe we should give freer reign to the destructive half of the Oedipus complex.

District Branch News

Michigan—*Foster-Care Study*

Douglas A. Sargent, M.D., director, Wayne County Juvenile Court Clinic for Child Study, has announced the receipt of a $270,000 NIMH grant to study emotionally disturbed boys between the ages of 8 and 12 in especially established foster homes. The study is to explore means to increase "the 'holding power' of foster homes over failure-prone children." A significant element in the program will be emphasis on working with the childrens' parents during the placement period and seeking their consultation on the problems that the foster parents encounter.

New Jersey—*Low-Cost Psychotherapy Plan*

A unit to provide low-cost psychotherapy, established as a pilot project four years ago by the Mental Health Association of Essex County, began operation as an independent agency July 1.

The program provides an outpatient service for marginal-income families. If a patient needs the services of a therapist, he is accepted for treatment. Each therapist receives $5 an hour, and none is permitted to contribute more than five hours a week. Patients pay a maximum of $5 per visit, and in cases where they cannot afford the full fee, the treatment is subsidized by the association. A panel of 37 psychiatrists and psychologists work in the program. Bernard Chermin, M.D., who has been serving as a panel member, will become medical director of the unit. Harold Gordon, a psychiatric social worker, is the administrative director.

The county mental health group will continue to give financial support to make up the difference between the actual cost and monies received from federal grants, patients' fees, and foundation grants. The current annual budget is $49,000.

Ohio—*Mental Hygiene Budget Cut*

The Ohio Legislature cut the Division of Mental Hygiene's budget for the 1961-63 biennium by nearly 7 million dollars. According to the Ohio Psychiatric Association, the budget presented to the Legislature was a minimum or *status quo* budget, with no provision for needed expansion or salary increases.

According to an editorial in the Ohio Psychiatric Association's newsletter, no one in medicine or psychiatry was consulted, and very little opposition was voiced. The editorial exhorts medical and particularly psychiatric personnel to be more aggressive in political matters when progressive programs are threatened, especially where they are better informed than the average citizen.

New York—*Professional Standards*

The Professional Standards Committee of the Nassau Neuropsychiatric Society has recommended to the Society's Executive Committee that any teaching or supervision of lay therapists, except in clinics, should be terminated pending a working agreement with the other professional societies concerned.

Virginia—*Nondirective Counseling for Clergy*

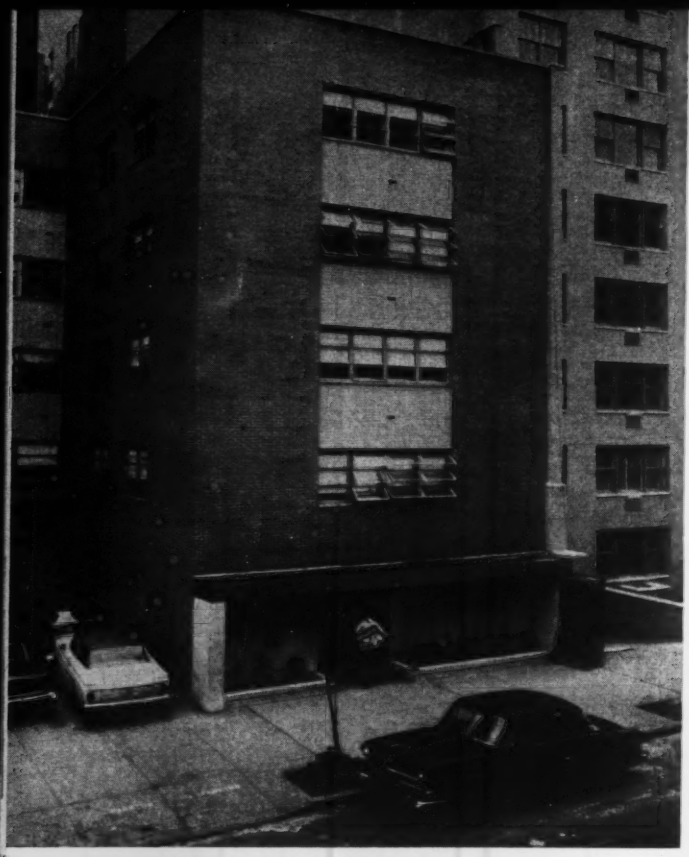
The Waynesboro Ministerial Group recently completed a six-weeks' course in nondirective counseling for clergy conducted by William M. Sheppe, Jr., M.D., of the Department of Neurology and Psychiatry, University of Virginia Hospital, Charlottesville. This seminar is part of the department's general program in social psychiatry, designed to make certain psychiatric skills and counseling techniques available to nonpsychiatric personnel.

—Plans for a New State Hospital

Alexandria, Arlington, and Fairfax counties have jointly approved plans for the development of a state hospital in northern Virginia. Alice Kiessling, M.D., head of the Department of Psychiatry at Arlington Hospital, recently appeared before the State Hospital Board, with a large group of citizens from the three counties, to urge adoption of the plans.

Wisconsin—*Support of Proposed Legislation*

A bill concerning the organization of service corporations by professional men and others was introduced recently in the Wisconsin Legislature. The bill, similar in intent but not in form to the Jenkins-Keogh type of federal legislation, provides for the formation of legal corporations by one or more professional men for the purpose of providing retirement funds *before* taxation. Members of the Wisconsin Psychiatric Association have written to the Wisconsin Assembly Taxation Committee conveying their support of the bill.



The Psychiatric Treatment Center opens on September 11. Its program is geared to adolescents and young adults.

A DESIGN FOR ADOLESCENT THERAPY

By the Staff of The Psychiatric Treatment Center
New York, New York

The Psychiatric Treatment Center opened in midtown Manhattan on September 11, 1961, for the purpose of treating adolescents in a combination inpatient and day-hospital setting, with no locked doors. It is housed in a modern five-story, two-elevator building. Some physical modifications will be made to meet the adolescent-treatment program as it develops.

The center, which accommodates 30 resident-patients, is licensed by the New York State Department of Mental Hygiene as a private psychiatric hospital, but makes every endeavor to avoid the appearance or atmosphere of an institution. The decor is reminiscent of a teenagers' residential club. The two top floors contain patients' rooms, each designed as a sitting room and convertible into a sleeping room for one or two people.

The third floor is equipped for such activities as art work, the performing arts, and indoor sports like pingpong and billiards. The professional offices are on the second floor. The first floor contains administrative offices, some additional professional space, and a large dining room with an outdoor terrace used for meals and activities. The roof also has space for outdoor games. There is a large modern kitchen in the basement.

Preference is given to young people between 15 and 20 years of age, although the center admits selected older patients. There will be two or three professional staff members to each patient.

The intensive treatment program for adolescents is based upon the principles described in the following paper, and a research program, financed by the profits from patients' fees, will be closely integrated with the service functions of the center.

The program was developed by a number of professional staff members, in particular the following: Julian I. Barish, M.D., Director of Training; Bruce Buchenholz, M.D., Director of Research; George W. Naumburg, Jr., M.D., Clinical Director; and Edward Preble, A.B., Director of Program Therapy. At the request of these collaborators, the paper presented herewith is simply signed "The Staff of Psychiatric Treatment Center."

THIS PAPER DESCRIBES a new design for the treatment of disturbed adolescents. The plan combines traditional psychotherapy with a new technique known as "program therapy"—a synthesis of therapeutic intervention with a special kind of behavior analysis. The therapeutic staff will consist of psychiatrists with special training in psychodynamics, and a group designated as "program therapists," who have been selected on the basis of their demonstrated ability to work with adolescents. This group crosses conventional professional lines, and includes psychiatric nurses, psychologists, social workers, and other social scientists.

The Problem

Psychiatric treatment of adolescents has not kept pace with psychiatric understanding of them. It is difficult to establish understanding and communication between adolescents and adults. Under normal conditions, this difficulty is a natural and inevitable consequence of the adolescent's emerging independence and identity, and his development is well worth the price of adult discomfort. When, however, the adolescent's adaptive capacities break down, the disruption in communication becomes a serious problem instead of a mere annoyance. Psychotherapy with children, adults, or adolescents demands emotional understanding between the therapist and the patient. The establishment of such rapport between adolescent and therapist requires an unusual, and to some extent, unnatural effort from both.

Another widely recognized problem in the psychiatric treatment of adolescents is their vast and impatient energy. This phenomenon, too, is a natural stage in human development. It holds promise of a productive adult life and is of immediate value on the football field or dance floor. It is not, however, compatible with the demands of traditional psychiatric treatment which proceeds on a fixed schedule of between one and five hour-long sessions of sedentary introspection and discussion each week.

Even the setting of the doctor's office is an obstacle to effective treatment. A common feature in most adolescent disorders, whether they take the form of retreat or rebellion, is the individual's sense of separation from his peer group and from the community at large. Normally, it is at this stage of maturation that social attitudes (cooperation, loyalty, tolerance) reach a high level of development and influence the course of the individual's life as a contributing member of society. These social emotions cannot develop properly in the isolated environment of the doctor's office where the sense of separation may even be reinforced. They must emerge through experiences in the real world.

The Program

Program therapy is analogous to play therapy with children. The therapist has the opportunity to take part in meaningful activities with the patient in order to communicate with him on a natural level and to exert a therapeutic influence within an emotionally significant context. The activities, specifically oriented to the patient's therapeutic needs, provide a setting which is not too confining for his restless energy.

"Activity analysis" is one feature which distinguishes this treatment plan from others which it resembles superficially. In addition to the conventional admissions work-up, the psychiatrist determines which activities have emotional significance to the patient. This analysis records activities in which the patient participates, those in which he would like to take part but cannot, and those he avoids. It includes a historical account of his characteristic style of participation, from his childhood play habits to his contemporary activity patterns.

This is where the analogy between program therapy and play therapy breaks down. A small child's play is diffusely structured and similar in broad outline to that of other children in the same culture. The activities of adolescents, on the other hand, are more highly differentiated, better integrated, and more individualized.

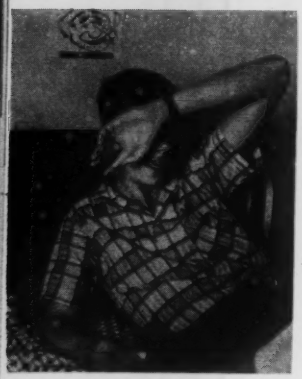
The psychiatrist integrates the activity analysis with the psychodynamic analysis to provide a rationale on which the program therapist may base his work. Although each program is planned initially on the basis of the admissions work-up, subsequent modifications develop empirically, on the basis of the increased understanding of the professional staff and changes which take place in the patient. The program therapist accompanies the patient whenever this serves the patient's need. He may be a companion therapist in school, in the home, or at a community function; as many daytime activities as possible are conducted off the premises. The center provides residential care for those who need it, but makes every effort to minimize separation from the community. There are no locked doors, no uniformed nurses, no attendants, no chart racks. Program therapy can take place in the center for those who cannot go out and for those who can go out only for a limited time.

The program therapist is trained in psychodynamics, in self-awareness and in the techniques of observation and psychodynamic inference, and their uses in program therapy. His work with a patient is supervised and reviewed in daily conferences with the psychiatric staff. During these conferences, the patient's progress in psychotherapy and in program therapy are discussed, analyzed, and correlated.

None of the children in these photographs are patients.

Accentuated communication problems between adults and disturbed adolescents make therapy unusually difficult.

Mutual interest in photography enables therapist to establish communication with patient; therapeutic influence will follow.



The close companionship of program therapist and patient is an essential part of therapy; they suffer through many crises.

A HYPOTHETICAL CASE HISTORY

Thus, although the program incorporates features of play therapy, occupational and recreational therapy, milieu therapy, and other specialized techniques, it is essentially different from any one or any combination of these. Its significant elements are the formal technique of activity analysis; the day-to-day program therapy; the daily integration of activity analysis with psychodynamic analysis, and of program therapy with psychotherapy; and an attempt to carry out the coordinated therapeutic effort whenever possible off the premises of the center and in the general community. A simplified hypothetical case history will illustrate:

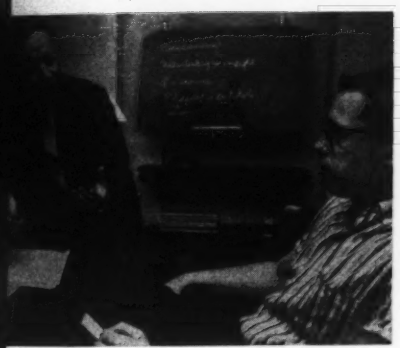
Suppose that activity analysis has disclosed that a schizoid youth is an enthusiastic amateur photographer, that he goes to the movies twice a week, watches adventure programs on television, and enjoys walking on the neighborhood bathing beach. The importance of visual activity is obvious; passivity is also apparent. These behavioral tendencies become especially significant in the light of the psychodynamic analysis which has disclosed voyeuristic-exhibitionistic trends and a strong rivalry with two sisters several years older than the patient.

A program therapist, basing his approach on the admission study, engages the patient's interest by demonstrating his new camera. Their mutual interest in photography is exploited to the point where therapist and patient go on picture-taking expeditions to a nearby park.

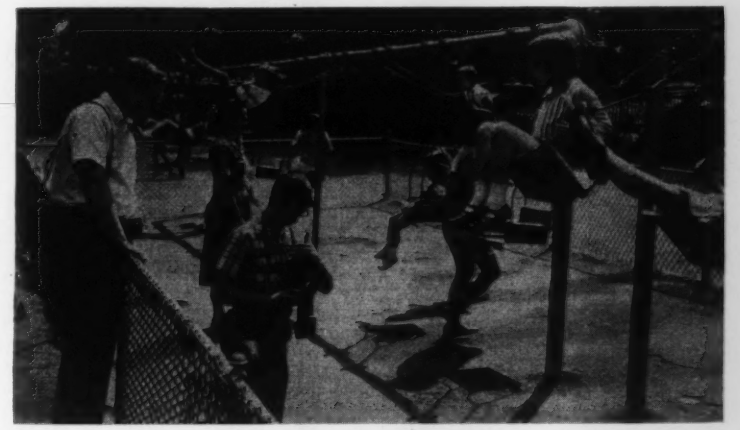
At the daily conference with the psychiatrist the program therapist reports that the patient prefers action photographs of children at play, and is especially intrigued by the patterns formed by the playing groups against the grass. The psychotherapist mentions that

Camera-toting outings enhance relationship, lessen "separation" from the world.

Looking down from his adolescent height, patient observes patterns made by playing youngsters against the grass. His dynamic analysis—



—suggests to psychotherapist connection of present behavior to sibling problems.



On next playground visit, therapist suggests picture of children using jungle-gym; patient flushes on seeing that children above him are girls.

the patient has dreams of piloting helicopters. The similarity between "looking down" on children playing, "looking down" on bathers sprawled on the sand, and "looking down" from a helicopter suggests a desire for ascendancy. This might be related to the patient's rivalry with his sisters.

On the following day during a picture-taking expedition, the program therapist remarks that some children playing on top of a jungle-gym form an interesting pattern against the clouds. The patient at first shows no interest, but with encouragement does look up and flushes when he recognizes that the playing children are girls.

The program therapist refrains from further intervention, but reports the sequence during the next day's conference. The psychiatrist is able to use this data in his next session with the patient. The patient becomes aware of his sense of inferiority to his sisters and of his unconscious desire to be a girl so that he, too, might be a favored and superior being.

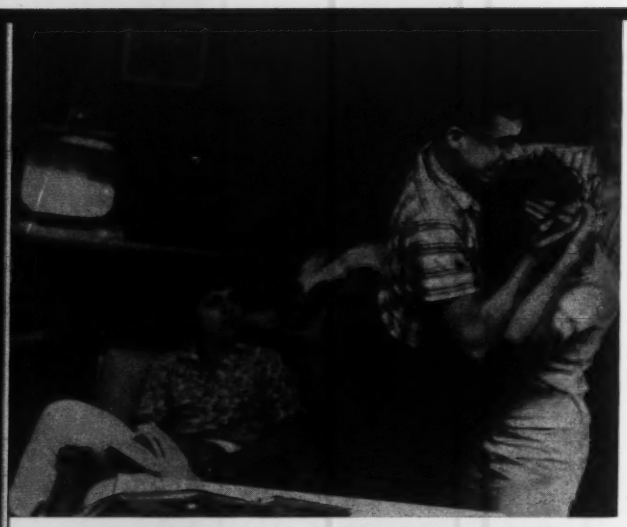
The program therapist uses the psychiatrist's analysis to initiate a plan that leads eventually to the patient's working through of these problems. Using their mutual interest in photography, and the patient's growing masculine identification with him, he steers the daily activities to photographing sports events. From this it is a logical step to active participation in sports, and the patient's gradual development of a new set of values and a new self-concept. This process, of many months' duration, involves a complex counterpoint between program therapist, psychiatrist, patient, other staff, and other patients.

The Principles

The program has been designed to implement the following principles:

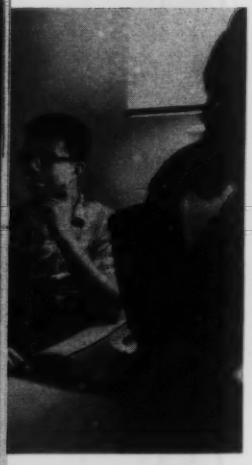
Each patient's unique combination of personality, circumstance, and pressures must dictate the form of his therapy. Each individual program should be planned and oriented to effect psychodynamic change as well as relief of symptoms.

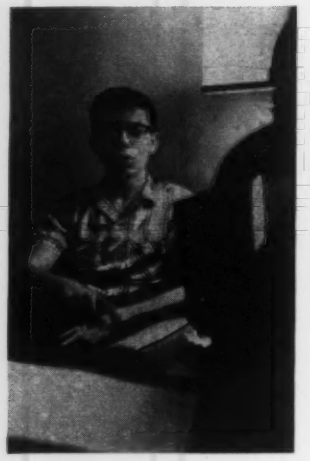
The patient's entire stay at the center, and every hour of his stay, should be therapeutic. One hour of



His emotional outbreaks have their roots in the boy's rivalry with his older sisters, his need for ascendancy.

Discussion of patient's progress in psychotherapy and program therapy during staff conference confirms dynamics of problem.





During his next session with the psychotherapist, the boy himself begins to gain insight into his difficulties. He becomes aware of his unconscious desire to be a girl, in order to gain the "ascendancy" enjoyed by his two elder sisters.

Active instead of passive pastimes result from boy's dawning insight, and masculine identification with program therapist.

verbal therapy is not enough. The greater part of the patient's time should be spent with trained professional personnel. All activities must exert the specific therapeutic influence needed for his individual psychodynamic constellation.

Finally, except when absolutely necessary, the patient should not be removed from an ordinary environment. He should engage in as many activities as possible in the general community rather than on the physical premises of the center.

Careful records are being kept on the observations of program therapists and psychiatrists in a continuing effort to establish and test specific criteria for the selection of therapeutic activities. The entire operation will function in the context of evaluation, assessment, and validation. Studies planned include techniques for evaluating clinical change, the significance of various aspects of each patient's program, systems for making clinical decisions, and the therapeutic efficacy of program therapy. •

Although depression is a common component of problems seen in medical practice, the classical symptoms of depression are seldom obvious. Much more frequently, depression lurks in the background . . . is often masked by physical symptoms such as fatigue, insomnia, poor appetite and weight loss . . . is frequently detectable only by careful questioning.

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CAUTIONARY COMMENTS

The author acts as the Devil's Advocate in an attempt to remind readers of *ACTION FOR MENTAL HEALTH* that some recommendations may need critical evaluation before adoption

By SIDNEY J. TILLIM, M.D., *Superintendent*
Nevada State Hospital
Reno

THE FINAL REPORT OF THE JOINT COMMISSION on Mental Illness and Health is an encyclopedic document prepared under the auspices of a dedicated group of people. The director of the project, Dr. Jack R. Ewalt, is a man of the highest qualifications, of visionary purpose, and unmatched zeal. The report was intended to offer a blueprint for a national action program on the problems of mental illness. It is comparable to the Old Testament in that its comprehensiveness is enormous and that neither could have been written by one person. Unfortunately, as with the Scriptures, even Satan may quote it with profit.

Parts of it may stand the test of time, but much of it is already outdated. The report's acceptance by 42 out of 45 of the members of the Commission is no more conclusive of its infallibility than is the literal acceptance of the Old Testament by the fundamentalist religious groups.

Over-activism May Cause Problems

Notwithstanding the claim that the final report is the first document "in American history that attempts to encompass the total problem of support for mental health services," we should examine critically a few of the flaws in the plan. Neither professional nor lay sound judgment can accept its thesis that everybody should get into the act of doing something about mental health. In the first place, there is no agreement as to what really constitutes community or individual mental health. The title itself is misleading. What kind of mental health should we strive for—that depicted by the Nazi-Fascistic culture, or that proposed in Huxley's *"Brave New World"*? Can individual mental health be doled out by prescription to supplement each person's "given potential for mental health or illness"?

In the absence of knowledge or agreement about the causes of mental illness, it is misleading to compare its eradication with that of certain communicable or nutritional diseases. We accept complex "biological, psychological and sociological forces" as influencing behavior and these factors are not readily modified by teachers of the humanities or by physicians. Nor can mankind stay the tide of material "progress" in order to improve societal mental health.

People participate in mental health activities for various individual objectives: the physician by his election of a specialty; the parameter experts often as aborted physicians; the social scientists to expand the interest of their otherwise dehumanized specialties; and, on the fringe, gregarious failures who wish to manipulate the lives of other people. Unfortunately, the latter are too often in positions of leadership, and, with the laudable intention of serving unhappy humanity, are a potential danger to fellow men.

Physicians are dedicated to tending the sick, to do nothing to harm them, to heal if possible, and to palliate disease whenever possible. Even an acute shortage of qualified personnel does not justify us in allowing dangerous people to join our "team" operation. We psychiatrists should be especially alert to the inherent danger of accepting such people and allowing them to influence public thinking. We should be equally alert to the danger posed by some who practice physical medicine; "chiropractic psychiatrists" are already known in some areas, and physicians, unfamiliar with psychiatric problems, are practicing hypnotherapy.

Dangers of "Chronic Disease" Concepts

A number of ultra-conservative proposals in the final report show unfamiliarity with certain phases of hospitalization for mental illness. The proposal that large mental hospitals be converted into general rehabilitation centers for chronic ailments—physical as well as mental—ignores the unacceptability that would be the fate of such centers. Amputees, cardiacs, rheumatics, and those with other chronic ailments are

no more likely to be tolerant toward the lowly "mental patient" than are the general public. Nor will placing such facilities under the stewardship of lay administrators improve the situation. What will prevent such mammoth facilities from developing the unsavory status of the old mental hospitals?

Loula Dunn, one of the three dissenting members of the Commission said "nothing can be gained by perpetuating the concept of the independent chronic disease hospital." The proposal, while it may reduce the number of patients on the back wards in public mental hospitals, could also create third- or fourth-rate human beings, a classification that not only the Commission but the Bill of Rights seeks to eliminate.

The report recommends that public mental hospitals should not have over 1,000 beds for intensive treatment—a compromise recommendation which ignores many of the discussions which have taken place since 1958 when Dr. Harry Solomon declared, in his presidential address, that the mammoth state hospitals should be liquidated and turned into smaller, independent, complete units for the purpose of intensively treating acute psychiatric disorders. Commissioners and superintendents for the most part rejected the idea for the foreseeable future. Dr. Francis J. O'Neill, at the 1961 APA Annual Meeting, belabored the issue of larger versus smaller institutions. He called for a "scientific evaluation of the therapeutic potential of the mental hospital in relation to its size." Basing his statement on his personal experience, Dr. O'Neill doubts that "patients receive any better treatment or have any better chance of recovery in a small hospital because of its size alone," although he does admit "that there are advantages in the small hospital." Quite a self-contradiction!

Economic Versus Therapeutic Considerations

Dr. O'Neill casually injects the economic factor. It has been pretty well established that smaller institutions, beyond a certain minimum capacity, can operate with comparative economy. The small institution may be seen as a country store in comparison with the huge cosmopolitan department stores—no less effective in services than its big brothers. It has the immediate advantage of offering personal service and personal interest to its customers—when its customers are mental patients, this is a valuable attribute.

Thousand-bed hospitals cannot be effectively superintended as medical institutions even with ample staff. Physicians cannot personalize their interest in so many patients at one time. If the report's recommendation and Dr. O'Neill's defense of large institutions are taken seriously, then the unsettled debate over the merits of lay versus medical superintendents becomes purely academic. The superintendent's functions are reduced to mass administrative decisions, not individual medical ones. Medical judgment is not always needed for mass dispositions.

The splintering of large institutions is already underway in many parts of the country. This reformation merits watching for its effects on future admissions. If there is a medical superintendent for each unit of say 500 patients, ancillary services for common use can be retained under separate supervision—*i.e.*, acute medical and surgical service, laboratory and X-ray facilities, food services, heating and maintenance, etc. This would have the salutary effect of allowing the heads of each unit full responsibility for the quality of the service. It would provide varied clinical experience for physicians working in such units, and thus remove the hazard of deadening boredom and discouragement.

Need for Delineation of Functions

Turning to community facilities, the report finds that mental health clinics are in a "pivotal position" as "the fulcrum of effort to remove the barriers isolating mental hospitals from the community." Such facilities are to treat the acutely mentally ill, who do not need hospitalization, and provide follow-up service for discharged patients. Community mental health education, recommends the report, should be "left with the health departments and mental health associations." This recommendation contrasts with the proposals urged at the 1960 Mental Hospital Institute by psychiatrists, who advocated greater involvement of hospitals in community-type activities, including the operation of clinics. With rare exceptions, persons responsible for the operation of mental hospitals do not possess special attributes to qualify them for operation of community-based outpatient services.

Nothing short of clear delineation of community versus hospital will produce effective state programs. Overlapping and conflicting assignments for public agencies lead to deficiencies in service. An acceptable plan for organization for the operation of total state programs is still needed.

A substantial part of the report is devoted to the topic of research. The need for more research is amply documented, but the suggestion that it be supported in every nook and cranny "out of the *wish* to do something" is not a convincing reason for the use of public funds. We have a responsibility beyond meeting the demands of the alarm-minded and action-oriented American public. It seems best to make maximum investment in research centers rather than to finance search-parties looking for a needle in a haystack.

Dogmatism is out of place as long as "scientists face (the) task with an incredibly small fund of knowledge." The report purports to urge improvements in the treatment of the hospitalized mentally ill. But some of its observations go far beyond such urging. The Commission, admitting that mental health progress still depends on "informed guesses of mental health practitioners" and is "an article of *scientific faith* rather than an applicable scientific truth," missed an opportunity by not distinguishing between faith and truth. A more fruitful document would have resulted from fewer debatable recommendations and more carefully considered objectives. •

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ADMINISTRATION AND DOSAGE: Dosage of 'Stelazine' should be adjusted to the needs of the individual.

Because of the inherent long action of 'Stelazine', patients may be controlled on convenient b.i.d. administration; some patients, on once-a-day administration.

Adult Dosage for Use in Psychiatric Practice

oral (for office patients and outpatients with anxiety): The usual starting dosage is 1 mg. or 2 mg. b.i.d. In the treatment of these patients, it is seldom necessary to exceed 4 mg. a day. (Some patients with more severe disturbances, and discharged mental patients, may require higher dosages.) In some patients, maintenance dosage can be reduced to once-a-day administration.

oral (for patients who are either hospitalized or under adequate supervision): The usual starting dosage is 2 mg. to 5 mg. b.i.d. (Small or emaciated patients should always be started on the lower dosage.)

The majority of patients will show optimum response on 15 mg. or 20 mg. daily, although a few may require 40 mg. a day or more. It is important to give doses that are high enough for long enough periods of time—especially in chronic patients.

Optimum therapeutic dosage levels should be reached within two or three weeks after the start of therapy. When maximum therapeutic response is achieved, dosage may be reduced gradually to a satisfactory maintenance level.

intramuscular (for prompt control of severe symptoms): The usual dosage is 1 mg. to 2 mg. (½-1 cc.) by deep intramuscular injection q4-6h, p.r.n. More than 6 mg. within 24 hours is rarely necessary. As soon as a satisfactory response is observed, oral medication should be substituted at the same dosage level or slightly higher.

Only in very exceptional cases should intramuscular dosage exceed 10 mg. within 24 hours. Since 'Stelazine' has a relatively long duration of action, injections should not be given at intervals of less than 4 hours because of the possibility of an excessive cumulative effect.

'Stelazine' Injection has been exceptionally well tolerated; there is little, if any, pain and irritation at the site of injection.

Dosage for Psychotic and Mentally Defective Children

The dosages given below apply to children, ages 6 to 12, who are either hospitalized or under adequate supervision.

oral: The starting dosage is 1 mg. administered once a day or b.i.d., depending on the size of the child. Dosage may be increased gradually until symptoms are controlled or until side effects become troublesome. Both the rate and the amount of dosage increases should be carefully adjusted to the size of the child and the severity of the symptoms, and the lowest effective dosage should alway. .e used. Once control is achieved, it is usually possible to reduce dosage to a satisfactory maintenance level.

In most cases, it is not necessary to exceed 15 mg. of 'Stelazine' daily. However, some older children with severe symptoms may require, and be able to tolerate, higher dosages.

intramuscular: There has been little experience with the use of 'Stelazine' Injection in children. However, if it is necessary to achieve rapid control of severe symptoms, 1 mg. (½ cc.) of 'Stelazine' may be administered intramuscularly once or twice a day, depending on the size of the child. Once control is achieved, usually after the first day, the oral dosage forms of 'Stelazine' should be substituted for the Injection.

SIDE EFFECTS: *In the dosage range of 2-4 mg. daily,* side effects from 'Stelazine' are infrequent. When they do occur, they are usually slight and transitory. Mild drowsiness occurs in a small percentage of patients; this usually disappears after a day or two of 'Stelazine' therapy. There are occasional cases of dizziness, mild skin reaction, dry mouth, insomnia and fatigue; rarely, neuromuscular reactions (extrapyramidal symptoms).

In hospitalized psychiatric patients receiving daily 'Stelazine' dosages of 10 mg. or more, clinical experience has shown that, when side effects occur, their appearance is usually restricted to the first two or three weeks of therapy. After this initial period, they appear infrequently, even in the course of prolonged therapy. Termination of 'Stelazine' therapy because of side effects is rarely necessary.

Side effects observed include dizziness, muscular weakness, extrapyramidal symptoms, anorexia, rash, lactation and blurred vision. Drowsiness has occurred, but has been transient, usually disappearing in a day or two.

Extrapyramidal Symptoms

These symptoms are seen in a significant number of hospitalized mental patients receiving 'Stelazine'. They may be characterized by akathisia, be of the dystonic type, or they may resemble parkinsonism.

akathisia: Some patients may experience an initial transient period of stimulation or

jitteriness, chiefly characterized by motor restlessness and sometimes insomnia. These patients should be reassured that this effect is temporary and will disappear spontaneously. The dosage of 'Stelazine' should not be increased while these side effects are present.

If this turbulent phase becomes too troublesome, the symptoms can be controlled by a reduction of dosage or the concomitant administration of phenobarbital or some other barbiturate.

dystonias: These symptoms are rare outside of mental hospitals, but they may be observed occasionally in patients who have received 'Stelazine' as a mild tranquilizer.

Symptoms may include: spasm of the neck muscles, sometimes progressing to torticollis; extensor rigidity of back muscles, sometimes progressing to opisthotonos; carpopedal spasm, trismus, swallowing difficulty, oculogyric crisis and protrusion of the tongue.

The onset of the dystonias may be sudden. A primary characteristic of these symptoms is their intermittency. They may last several minutes, disappear and then recur. There is typically no loss of consciousness and definite prodromata are usually present. Initially, these intermittent symptoms occur in a crescendo of intensity. Then as the effect of the drug wears off, the intervals between the occurrence of symptoms become longer, and the intensity of the symptoms subsides. Despite their similarity to symptoms of serious neurological disorders, these dystonias are usually promptly reversible and need not cause undue alarm. They usually subside gradually within a few hours, and almost always within 24 to 48 hours, after the drug has been temporarily discontinued.

Treatment is symptomatic and conservative. *In mild cases*, reassurance of the patient is often sufficient therapy. Barbiturates are also useful. *In moderate cases*, barbiturates will usually bring rapid relief. The dosage and route of administration of the barbiturate used should be determined by the intensity of the symptoms and the response of the patient. *In more severe adult cases*, the administration of an anti-parkinsonism agent produces rapid, often dramatic, reversal of symptoms. Also, intravenous caffeine and sodium benzoate seems to be an effective and rapid antagonist to the dystonias. *In children*, reassurance and barbiturates will usually control symptoms. Dosage and route of administration should be determined according to the intensity of symptoms and response of patient.

Note: It has been reported that injectable administration of Benadryl* may also be helpful in controlling dystonias.

pseudo-parkinsonism: These symptoms are extremely rare outside of mental hospitals. Symptoms include: mask-like facies; drooling; tremors; pillrolling motion; and shuffling gait.

Reassurance and sedation are important components of effective therapy. In the majority of cases these symptoms are readily reversible when an anti-parkinsonism agent is administered concomitantly with 'Stelazine'. Occasionally it is necessary to lower the dosage or to temporarily discontinue the drug.

CAUTIONS: Clinical experience has demonstrated that 'Stelazine', a phenothiazine derivative, has a wide range of safety and that there is little likelihood of either blood or liver toxicity. The physician should be aware, however, of their possible occurrence.

One of the results of 'Stelazine' therapy may be an increase in mental and physical activity. In some patients, this effect may not be desired. For example, although 'Stelazine' has relieved anxiety and, at the same time, anginal pain in patients with angina pectoris, a few such patients have complained of increased pain while taking 'Stelazine'. Therefore, if 'Stelazine' is used in angina patients, they should be observed carefully and, if an unfavorable response is noted, the drug should be withdrawn.

Hypotension has not been a problem, but nevertheless adequate precautions should be taken when the drug is used in patients with impaired cardiovascular systems.

The antiemetic action of 'Stelazine' may mask signs of overdosage of toxic drugs or may obscure the diagnosis of conditions such as intestinal obstruction and brain tumor.

Although 'Stelazine' has shown very little potentiating activity, caution should be observed when it is used in large doses in conjunction with sedatives or depressants.

CONTRAINDICATIONS: 'Stelazine' is contraindicated in comatose or greatly depressed states due to central nervous system depressants.

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*Trademark Reg. U.S. Pat. Off.: 'Benadryl' for diphenhydramine hydrochloride, Parke-Davis.

A Mental Hospital Makes Inroads into the Community

By ARTHUR SEALE, M.D., *Superintendent*
and RONALD S. PRYER, Ph.D., *Chief Psychologist*
Central Louisiana State Hospital
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PSYCHIATRY HAS COME A LONG WAY since the turn of the century when a mental hospital was a fortress-like structure completely isolated from the community. Today, the public no longer thinks of the mental hospital as an eerie place where incurables live under semiadequate conditions and are kept chained to the wall. People are accepting modern mental hospitals as institutions where the mentally ill are treated medically and inspired and encouraged to regain their places in society.

With new methods of diagnosis and treatment, both psychological and organic, we are succeeding more than ever in relieving the painful effects of mental illness. Far too often, however, the patient leaves the hospital hoping to lead a productive, well-adjusted life, only to return a few months or years later, incapacitated once again.

In recent years, after achieving reasonable success in the treatment and rehabilitation of the mentally ill patient, we have turned our attention toward finding ways of helping him to avoid returning to the hospital. In order to accomplish this goal, we are exploring virgin territory and planting new concepts that we hope will grow into a mature mental health program.

Community Cooperation

At Central Louisiana State Hospital, we are venturing beyond the confines of our institution, endeavoring to become an integral part of the community. We are gratified to find that, as our working relationship with the community improves, the biases of superstition and ignorance are gradually disappearing. With changing attitudes toward mentally ill people has come a willingness, on the part of the community, to assume some of the responsibility for their care and rehabilitation. The task at hand is to make maximum use of these changing attitudes and the many community resources that are now available.

Our past expeditions into the community have been in the form of strategically located outpatient centers, workshops for various professional groups, and similar ventures within the 30,000 square mile area served by the hospital. These have made communication between our hospital and the community more effective than ever before. Improved communication has resulted in better understanding of the mentally ill person, making it easier for him to resume his life in the community and decreasing his chance of rehospitalization.

Most recently, we have conducted discussion groups and educational programs for the relatives of our patients. Last year, we sent letters to relatives inviting them to attend one of four monthly meetings where they would have an opportunity to learn about various aspects of mental illness. The main purpose of the meetings was to help change the attitudes of the patients' relatives toward mental illness. We were concerned because many of our patients who made significant advances toward recovery in the hospital had to return to the same stress-filled environment that had precipitated their illnesses. In many such cases, it soon was necessary for them to come back to the hospital for further treatment. We hoped the meetings would improve this situation.

The initial response was most satisfactory. Every Sunday from 50 to 200 eager relatives, ready to learn about the "mysteries" of mental illness, attended the meetings. In an all-out effort to dissipate some of their misgivings, we had learned professional people tell them what we thought they should know. Each meeting was followed by an audience participation period, but, as it happened, there was little response from the relatives.

When attendance began to drop, we made an evaluation to search for the flaw in what we had believed was going to be a successful program. Through conferences with relatives, patients, and staff members, we learned that our major mistake had been

In a relaxing atmosphere, relatives of mental patients question an informed panel about the problems of mental illness.

to tell the relatives what we *thought* they wanted to know, instead of touching on some of the questions that deeply concerned them, personally. At the end of each meeting, they were so overwhelmed by the knowledge of the "experts" that they were somewhat shy and hesitated to ask questions they feared might be regarded as stupid.

Profit From Past Mistake

Immediately, we set about trying to correct our mistakes. This time we sent another mass invitation to our meetings, enclosing a questionnaire designed to solicit cooperation in finding the best ways for our hospital to serve the needs and interests of relatives. We left space at the end of each letter so that relatives could ask questions they would like to have answered about mental health. We received hundreds of replies and questions, and the first meeting boasted a record-breaking attendance.

This time our whole approach was different. Patients, serving as hostesses, greeted the relatives and escorted them to tables accommodating six or eight people. Patients served refreshments, and the over-all atmosphere was much more relaxed.

We divided the relatives' questions into 10 general categories: symptoms, therapy, etiology, prognosis, rehabilitation, religion, environmental factors, hereditary factors, and family and community relationships. A master of ceremonies read representative questions in each category to a panel made up of a psychiatrist, psychologist, social worker, psychiatric nurse, and chaplain. Each of the panelists commented on the questions. Then the MC opened the meeting to questions from the floor. This time the response from the audience was immediate and spontaneous.

Questions most frequently asked included: What is mental illness? Can it be cured? What causes it? What are some of the symptoms? Is it hereditary? Does shock treatment help? Why do patients build up hate for the ones they formerly seemed to love? When speaking to a convalescent patient, should we mention his illness or avoid the subject? How can we show the patient we want to help? Should we move to a new community where no one knows about the patient's illness?

One of the most avid questioners was a man who, with a somewhat belligerent attitude, came alone to a meeting several months ago. He was on the grounds to visit his wife, who had been returned to the hospital for the third time, and came to the meeting only after considerable urging by the nurse on duty.

Later, this man told the staff doctor, "You know, I'm sure I must have heard all the things that were talked about before, but somehow they never made the impact that they did in this meeting. It's no wonder my wife has been coming back to the hospital. I've been undermining her confidence in 10,000 different ways without ever realizing it. I guess I really came to the meeting with the idea of maybe getting assurance that there were a great many people who might get along all right inside the hospital, but who just couldn't make it outside. Frankly, I had prepared to fight to keep my wife in the hospital from here on. Now, I'm going to see if I can't help her to stay out." Apparently his efforts so far have been successful. His wife has not returned.

For the past six months, the program of family meetings has remained essentially the same, except for periodic changes in panel members. Attendance, interest, and the number of letters continue to increase. There is a certain amount of repetition in the meetings, but we find that regular attenders do not object to this. Perhaps the relatives wisely—even if unconsciously—recognize the meetings to be a measure of therapy for themselves.

We believe the program is highly successful now, and that we are satisfying, at least partially, the relatives' hunger for knowledge about how best to help their loved ones. Some relatives are visiting our hospital for the first time in years; they are enjoying themselves and taking a greater interest in our patients. Staff members, too, are receiving a good deal of pleasure from participating in the program. We hope that the program's effects will be reflected eventually in a decreased return rate and better adjustment on the part of our patients.

Televised Discussion Periods

In the very near future these discussion periods will be filmed for distribution to television stations throughout the state. Using this medium, we hope to tell people in our communities what they want to know, instead of what we think they should know. We believe that, in this way, we will not only get our message across, but will also elicit increased aid from the community. If citizens believe that we are aware of and are providing for their individual needs and interests, they are apt to be more eager to help us meet our own needs, which are identical to theirs—to achieve maximum health for every member of the community.

The time, effort, and money we have spent in making inroads into the community probably constitute the best investments we have ever made. Long ago, we realized that the wonders we accomplished inside our hospital meant little unless they could be communicated to and integrated into the various communities. If community efforts do not start before those of the hospital are necessary and take up where the hospital leaves off, attempts at complete rehabilitation cannot succeed as they should. Our goal is to get communities to realize that people who have behavioral disturbances are their problems and that the function of the hospital is to help in the best possible way to solve these problems.

Mental hospitals and communities are certainly two groups that urgently need mutual cooperation. By working together they can be more successful than ever before in defeating the nation's number one health problem. •

10 GREAT BOOKS IN THE HISTORY OF PSYCHIATRY*

BERNARD L. DIAMOND, M.D.
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A LONG TIME AGO I was audacious enough to compile a list of the 10 greatest books in the history of psychiatry. The difficulty is that I no longer agree with my own list. I have revised it innumerable times. It would be easy to select the 100 greatest books on psychiatry. But 10—and 10 only?

How should one decide? Should the books be those authored by the 10 greatest psychiatrists? The 10 most representative of our specialty? The 10 most widely read books? Or should they be the 10 books that have made the greatest contribution to our knowledge of psychiatry? And how does one weigh one contribution against another?

Of course, there is no answer to these questions. But if you, the reader, will accept my list in the spirit of a historical game – a bibliophilic pastime – I will try once again. But remember, it is likely that I will change my selections even before you have reached the end of this column.

Here, I have chosen the 10 books which I believe were most influential in the historical determination of the Gestalt of mid-twentieth century psychiatry. With all our dissensions and "schools," the 1961 psychiatrist shares with his colleagues a common matrix of scientific knowledge, humanitarian interest, and clinical skill in healing the mentally ill. Our similarities are greater than our differences. Therefore, I have selected the great books that shaped our profession as we know it today – the books that set the sturdy foundation upon which all else in psychiatry is but a superstructure.

It is convenient to my purpose to separate the two main themes of psychiatric history: first, its classical theme as a branch of medicine with categories of mental diseases to be defined in anatomical, pathological, and physiological terms; and the theme of medical psychology with its emphasis upon mental and emotional experience as the cause of disease, and dynamic psychotherapy as the remedy. (Suggested by my bibliophilic colleague, Dr. Norman Haskell, who is responsible for the selection of some of the books on this list.) Of course, this separation is artificial, and, perhaps, destroys historical continuity. Themes in history are never easily traced; they are more like the intricate, intertwined helices of the protein molecule. But to get on with the list. . . .

Classical Psychiatry

1) Weyer, Johann (1515-1588) *De praestigiis daemonum.* Basilieae, J. Oporinum, 1563.
Zilboorg calls Weyer "the founder of medical psychiatry." This book asserts, for the first time, that the witches who are burned at the stake are only harmless, senile, delusional, melancholic, old women.
2) Pinel, Philippe (1745-1826) *Traité médicophilosophique sur l'aliénation mentale ou la manie.* Paris, Richard, Caille & Ravier, ann IX (1801).
Pinel unchained the insane at Bicêtre and it was his book which gave the great impetus to the humanitarian revolution of the treatment of the mentally ill.
3) Tuke, Samuel (1784-1857) *Description of the Retreat, an institution near York for insane persons of the Society of Friends.* York, W. Alexander, 1813.
This description of the Retreat, founded in 1792 by Tuke's grandfather, set the pattern for all good mental hospitals of the future. The Retreat was the original therapeutic community.
4) Kraepelin, Emil (1856-1926) *Einführung in die psychiatrische Klinik.* Leipzig, J. A. Barth, 1901.
Kraepelin's classification of mental disease was a giant step forward. Before Kraepelin, all psychiatric nosology was as primitive as the four humors of Hippocrates. Kraepelin introduced the diagnoses of dementia praecox and manic-depressive psychosis and gave their clinical differentiation.

**Revised version of a column that appeared originally in the February 15, 1961 issue of the Newsletter of the Northern California Psychiatric Society.*

5) Bleuler, Eugen (1857-1939) *Dementia praecox oder die Gruppe der Schizophrenien.* Leipzig, Wien, F. Deuticke, 1911.
Bleuler coined the word schizophrenia. Nine tenths of all that we know about schizophrenia is contained in this book which marks the fusion point of psychoanalytic psychiatry with classical psychiatry, since Bleuler was much influenced by Freud's theories.

Psychotherapeutic Psychiatry

6) Mesmer, Franz Anton (1734-1815) *Mémoire sur la découverte du magnétisme animal. Genève, Paris,* P. F. Didot le jeune, 1779.
Whether one looks upon Mesmer as a charlatan or genius, one cannot deny that the historical roots of psychoanalysis and modern psychotherapy lead directly back to his animal magnetism.
7) Braid, James (1795-1860) *Neurypnology, or, the rationale of nervous sleep.* London, J. Churchill, 1843.
Braid introduced the word hypnotism. His theories became the foundation of the French school of hypnotism and psychotherapy by suggestion.
8) Liébeault, Ambroise Auguste (1823-1904) *Du sommeil et des états analogues.* Paris, Victor Masson et fils, 1866.
Liébeault founded the Nancy school and was the teacher of Bernheim. He was a country doctor who experimented widely with the use of hypnosis and suggestion. Liébeault was the first to knowingly substitute psychotherapy for hypnosis. Copies of his book are rare and little known to historians. Only one copy was sold when the book was published. Yet its influence upon Bernheim, Charcot, and Freud was immeasurable.
9) Charcot, Jean Martin (1825-1893) *Leçons sur les maladies du système nerveux faites à La Salpêtrière.* 3 Vols. Paris, A. Delahaye, 1872-87.
Charcot and his disciples at Salpêtrière wrote so many books of importance in the history of psychiatry and neurology that it is impossible to single out one as *the book.* These volumes of lectures are representative of Charcot's work. Charcot developed the French school in its ultimate flowering. Freud came to Salpêtrière to study and it was here that he became interested in the problem of hysteria. Charcot died in 1893. In the same year Breuer and Freud published the first paper on psychoanalysis: "Über den psychischen Mechanismus hysterischer Phänomene." Although the world did not yet know it, medical psychology moved, in 1893, from Paris to Vienna.
10) Freud, Sigmund (1856-1939) *Die Traumdeutung.* Leipzig, Wien, F. Deuticke, 1900.
The "Interpretation of Dreams" is the center of all psychoanalytic theory and practice. Freud's greatest book, it was actually published late in 1899. The publisher could not resist the temptation to date it forward into the new century. •

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VOLUNTEERS AS PSYCHIATRIC RESEARCHERS

By ROBERT J. WOLFF, Ph.D.*
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IN "the helping professions," the use of volunteers—even relying on them—is not new. However, the contributions they made to the recently terminated Minnesota Follow-up Study are unique in many ways. A corps of trained volunteer-interviewers provided all of the research data for the study by regularly interviewing a sample of more than 200 patients discharged from a state hospital and their families.

The Minnesota Follow-up Study, administered by the State Department of Public Welfare, was supported by a grant from the National Institute of Mental Health. It was conceived as a demonstration project with a dual purpose: (1) to evaluate the effectiveness of predischarge planning and follow-up care in terms of the post-hospital adjustment of patients, and (2) to record community factors that militate for or against adjustment.

The nature of the problems to be investigated and, to a lesser extent, the nature of the sample population ruled out the use of questionnaires sent through the mail to be filled out by the subjects. We thought we could obtain more reliable and meaningful evaluations from personal interviews. Also, an interviewer could track down a subject—who might disregard an impersonal letter—and often induce him to cooperate.

We decided to use volunteers primarily because we thought that there would be inevitable bias in evaluations made by staff members. It would be almost impossible for staff members to be objective while interviewing patients with whom they had casework relationships.

It is true that, at first, some of the professional staff believed that such an important task should be performed only by dedicated professional people. We were all too aware that the quality, accuracy, and validity of the interviews would be vital to the success of the study. Our initial apprehension, however, was replaced by complete reliance on the volunteers, who did a professional job—and did it well.

We carefully selected the volunteers. All had considerable education and experience and many had backgrounds in social work, nursing, psychology, and related fields. Some volunteered through the American Association of University Women, an organization that is active in the mental health field. In a very real sense, the volunteers were as "professional" as our staff personnel, although they were not on the payroll.

We organized our volunteer training program into about ten sessions. In some cases, these sessions were compressed into five days, with one held each morning and one each afternoon; they were real work sessions, lasting up to three hours without interruptions or breaks. We gave the volunteers a fairly thorough professional orientation in addition to training them in specific skills because we knew that the success of their later performance would be related directly to their training. The orientation program included stimulating discussion about psychopathology, questionnaire construction, interviewing techniques and ethics, etc. All interviewers acquired a "research orientation," which was amply illustrated in their subsequent work.

Supervision Encouraged Workers

After the initial series of training sessions, we maintained continuous supervisory contact with the interviewers. This informal supervision encouraged the volunteers' best performance and communicated the staff's acceptance of them as colleagues.

The pre-coded questionnaires required considerable interviewing skills in establishing rapport, eliciting answers, and interpreting content on-the-spot. At all times the interviewers had to be completely noncommittal; they could not influence the interviewees, and yet they had to communicate their competence, trustworthiness, and willingness to listen.

The interviewers worked an average of six hours a week. After receiving their weekly assignments, they arranged times and places for their interviews. In preliminary studies, we found that there did not seem to be a preferred way of arranging for an interview; we had about equal success in contacting a subject by letter, by phone, or at home without prior warning. We gave the interviewers sufficient information about each case so that they could determine the most desirable method of approach. Frequently, they had to conduct interviews in the late afternoon or evening because subjects or "centrally concerned others" worked or were otherwise unavailable during the day. Our delegation of this "approach" responsibility illustrated our complete confidence in the interviewers.

As we expected, there were problems related to the approachability of interviewees. We have reason to believe, however, that the volunteer interviewers did not "lose" any more interviews than paid professional people would have lost.

There were other problems. A few volunteers

**Dr. Wolff was formerly associated with the Minnesota Follow-up Study as project psychologist.*

left, either because they discovered that they were unable or unwilling to do this kind of work or because they moved out of the area. Many went out of town for the summer or, for other reasons, were unable to take on a consistently full work load. This meant that we had to attract new volunteers almost continually, plan new orientation courses from time to time, and arrange for other volunteers to take over temporarily.

Nonetheless, the volunteers did a remarkably skillful job in handling these highly structured interviews. None of them had had previous training or experience in this kind of interviewing, although most were trained and experienced in dealing with people. It was highly gratifying to learn that, in our materialistic society, it is possible for people to do difficult, disciplined, continuously supervised, and regular work without any of the customary material rewards. The volunteers' continued efforts proved their deep and lasting motivation.

What other kinds of rewards did they receive? Their own comments indicate that they found most gratification in doing a professional job well. All of the volunteers were intelligent women—many holding college degrees—who found satisfaction in using their talents and capacities in a professional setting for an institution that had high professional prestige. All of them were socially active, both before and after they volunteered for the study.

Some volunteers made considerable sacrifices to participate in the Minnesota Follow-up Study. They often had to hire baby sitters for the day so that they could travel 100 miles to do an interview. Those who did not have cars arranged to be driven to their interviews. They were surprised when we suggested that it was only fair for us to reimburse them for gas, at least; they wanted us to understand that they did not expect reimbursement.

It should be of considerable interest to all who work and rely upon volunteers to know that, apparently, there are a number of people in each community who need the gratification of doing a professional job. The rigorous research interviewing for the study did not necessarily replace our volunteers' other civic interests and activities; many continued to be as active as ever.

We hope that our enthusiastic experience with volunteers in a professional "job" may stimulate others to provide similar opportunities elsewhere. In view of the current emphasis on psychiatric research, it is practical to consider the use of trained volunteers in getting the job done more swiftly and completely. When volunteers are employed to help with projects such as the Minnesota Follow-up Study, they do not compete with staff personnel or threaten their jobs; if anything, volunteers reduce pressure on the staff and supplement their work in invaluable ways. •

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2. Laitner, W.: Psychiat. Quart. Suppl. II *29*:190, 1955.

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NURSING ROUTINES: MASTERS OR SERVANTS?

By T. AYLLON, Ph.D.
Behavior Research Project
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"ROUTINE IS THE GOD of every social system," said A. N. Whitehead. "It is the seventh heaven of business, the essential component in the success of every factory, the ideal of every statesman. The social machine should run like clockwork . . . it is the beginning of wisdom to understand that social life is founded upon routine."[1]

Routine, however, like alcohol, is a good servant, but a poor master. Recently, when we were attempting a research project on a 40-bed women's ward we found that the established ward routines left insufficient time for the nurses to collect the records of patients' behavior which we needed for the study. Upon careful examination, we discovered that the existing routines, far from facilitating ward administration, were actually limiting, not only the patients' activities, but the nurses' too.

Many of the established procedures were hallowed by 20 years or more of use; some were older than many of the nurses and a few of the patients. Nurses could rarely explain the purposes of the procedures they followed, and when pressed to do so, became flustered and exhibited irrational fears. The very esoteric nature of the routines and their great age apparently invested them with a magical quality. They had become ritual, serving no useful purpose, but nurses were afraid that something awful would happen if they were changed.

[1]*Whitehead, Alfred North: Adventures of Ideas, Penguin Books, 1948, p. 111.*

In an effort to determine exactly what procedures nurses did follow, we instructed them to report on their own work every 30 minutes. Within a few days, we had sufficient information to plan needed changes that would enable the nurses to carry out the research procedures as well as their normal nursing activities. The changes were possible because the senior author of the paper had *carte blanche* to carry out the research project, and the ward administrator is a nurse responsible for the autonomous administration of her ward.

There are five main routines: bathing patients, getting them up and putting them to bed, serving their meals, giving medication, and general administrative procedures. Despite overlapping, we shall discuss these routines separately for the sake of simplicity.

Every Night is Bath Night

Every patient had at least one bath a week, usually on Friday or Saturday, in the morning or early afternoon. Since the largest number of nurses were on the morning shift (7 a.m. to 3 p.m.), they were supposed to be responsible for the bathing chore. However, it sometimes took all day because of constant interruptions—treatments, meals, visiting hours, etc. The nurses tried to bathe all of the patients at the same time in assembly-line fashion, which resulted in much pushing and shoving and an occasional accident.

Under the revised routine, patients have their baths about 8:30 p.m., just before going to bed. Nurses only help those who refuse to take a bath at reasonable intervals. Bathing takes place every night, and only a third of the previous supervision is needed.

Before the change, many nurses said that night bathing would disturb and upset ward administration. A few thought that there were not enough night nurses to cope with disturbances. It is true that some patients were upset for a few days. One asked a nurse, "Are you crazy, bathing us this time of night?" But within ten days, everyone had settled down to the new plan, and there has been no further trouble. A nurse recently commented that patients like to bathe at night.

Under the old regime, lights-out was at 9 p.m., and we expected the patients to be in bed. However, nurses spent much time and effort coaxing them, undressing them, and even forcing them to retire. After lights-out, we found patients sitting in chairs, walking around, or lying on couches. Finally, we abandoned the arbitrary bedtime, and let patients retire when they wanted to without coaxing them or offering them physical assistance. We advanced the curfew to 11 p.m., and let the patients alone, permitting those who were still up to sleep in chairs or walk around the ward.

Nurses had feared that under this less rigid system, many patients would stay up all night and, perhaps, wander around shouting, smashing furniture, and generally creating an uproar. However, by 11

p.m. 90 per cent of the patients were in bed; about 50 per cent went to bed at 9 p.m.—the old time. The few who did stay up all night tried to sleep during the following day, but since loud noises, furniture moving, and the activities of others kept them awake, they were often the first to go to bed that night.

Previously, patients were called 30 minutes before a meal, and were expected to get to the dining room within this time. Staff spent the half hour calling patients, coaxing them, hunting for them, and if necessary, forcibly bringing them to the dining room. Patients who refused to eat for more than two or three days were fed with a spoon or tube.

Under the new routine, nurses call the meal, but allow patients to go to the dining room of their own volition. Within two weeks, 80 per cent were arriving on schedule. Those who didn't went without eating for varying periods, but most were having regular meals again within three to five days. No food is available on the ward except in the dining room at mealtimes, but the ward has a drinking fountain. We weigh each patient weekly, and if one shows a sudden weight loss, she is watched carefully for signs of dehydration.

Nurses Worried over Meals and Medications!

This was the change that worried the nurses most. They thought it was cruel not to help the patients; some feared they might starve themselves to death. They felt that we had abandoned the fundamental principles of psychiatric nursing. Once again, however, their fears were mostly unfounded. There were no harmful consequences, and the nurses began to realize that many patients who had seemed to depend upon help to get to the dining room could very well get there under their own steam.

We used to give medicine three or four times a day—one hour before meals and sometimes again at 8 p.m. The nurses took prepared medications to the ward, and after a preliminary call of "Medications, ladies," called each patient by name. Some patients gave no sign that they had heard. The nurses had to call, coax, and remind them, and supervise each one to make sure she had swallowed her dose. In spite of the fact that about two hours of nursing time was involved each day, some patients still had to have their medicine mixed with their food because they spat it out.

Patients now receive their medicine after each meal as they leave the dining room. (Should they miss a meal, a nurse is assigned to make sure they get the medication.) We find that patients need less persuasion and supervision and that less nurse and patient time is required to complete the medication procedure.

Between 40 and 50 per cent of the nurses' day had been spent doing such tasks as sorting laundry, writing monthly progress reports on patients, entering laboratory reports and weights on charts, copying medical orders on patients' files, recopying medication and treatment lists, and preparing requisition lists to replace worn-out clothing and get the new ward supplies. These duties fell to the day shift, and the supervising nurses double-checked them. The nurses were overworked, and little time remained for them to work directly with patients.

These duties and much of their supervision have been transferred to the night shift, leaving the day shift more time to spend with patients. The supervising nurse, relieved of her double-checking responsibility, supervises both nursing routines and the new research procedures. The nurses themselves like the change: the day shift can do more "real nursing," and the night shift is glad to have something useful to do during the long, lonely hours.

In any large organization, routines are necessary and inescapable, but they can easily become an end in themselves. When this happens, they hamper rather than help efficiency. Routines may become so old and comfortable that we forget their purpose—to make it easier to achieve certain goals which are reformulated from time to time. Once a year, our routines might profit by a good spring-cleaning. We should discard those which no longer serve our purpose and replace them with better ones. Only thus can we be sure that ward routines will assume their proper role as the useful servants of patients and nurses, not dictators which make our tasks more difficult. •

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*Ayd, Frank J., Jr.: Drug-induced Extrapyramidal Reactions: Their Clinical Manifestations and Treatment with Akineton. Psychosomatics 1:143 (May-June) 1960.

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Reviews & Commentary

FILM REVIEWS

PSYCHIATRIC TECHNIQUES FOR THE FAMILY DOCTOR (black and white, 55 minutes). Produced by CIBA in cooperation with the American Academy of General Practice. Available on a free loan basis from the following branches of Ideal Pictures: 233 W. 42nd St., New York, N. Y.; 58 E. South Water, Chicago, Ill.; 18 S. 3rd St., Memphis, Tenn.; and 1840 Alcatraz Ave., Berkeley, Cal.

As its title implies, this kinescope of a closed circuit telecast is intended for only one audience—physicians in general practice. It is appropriate to review it in this publication, however, because of the increasing involvement of mental hospital staffs with psychiatric orientation programs for physicians. Unlike most of the films reviewed each month, this one would not be useful for inservice training of nurses and aides; the cases shown are unlikely to turn up in a mental hospital and the interviewing techniques are intended only for a physician's use.

The late Dr. Robert Matthews, former Professor of Psychiatry at Jefferson Medical College in Philadelphia, Pa., opens the film by commenting on the physicians' growing interest in mental disorders. He describes situations, normally requiring referral of patients to psychiatric services, in which it is often possible for the GP to personally administer a limited kind of psychotherapy. To illustrate such cases, he introduces Dr. B. Wheeler Jenkins, who interviews three patients with emotional disturbances, none of whom required psychiatric referral. The cases include an older man with colitis, and a biologically and psychologically inadequate young man. During each interview, Dr. Matthews, the moderator, writes helpful clues and notes on a blackboard. These messages are superimposed on the image of the patient so that the continuity of the interview is not interrupted by the commentary. This simple device works very well, especially when Dr. Matthews wants us to note the patients' nonverbal communication. It also helps to make us aware of the patients' moments of insight.

Dr. Jenkins' interviewing is skillful and imaginative and conveys the impression that certain patients can benefit enormously from time given to them by an understanding physician. Without delving deeply into psychodynamics or theory, Drs. Matthews and Jenkins effectively demonstrate possible kinds of psychotherapy the physician can give to patients who require it. In a concluding colloquy, they emphasize the need for more psychiatric training opportunities for the GP.

"Psychiatric Techniques for the Family Doctor" is a highly informative and interesting film and should be useful to its intended audience. It is a unique contribution to the psychiatric orientation of the physician.

Preview of Institute Films

Several films illustrating psychiatric care abroad will be shown along with new domestic films at the 13th Mental Hospital Institute in Omaha. Although the final program has not yet been set, films are now being selected by staff members of the Mental Health Materials Center, film consultants to the APA Mental Hospital Services. Among the foreign entries likely to be seen are a film showing treatment of the mentally ill in Japan, one on a day-care facility for mentally disturbed children in England, and another about Belgium's famed community, Gheel. Definitely scheduled is a new British film, "Understanding Aggression," which approaches the problem from the standpoint of psychiatric nurses and aides. Canadian mental health films are too familiar to American audiences to be called "foreign," but it is probable that several from the series, "The Disordered Mind," will be shown with the foreign group. Another possibility from across the border is a film showing the medical uses of hypnosis.

In deference to the current interest in psychiatric training programs for the physician in general practice, a special group of films will be scheduled for viewing by mental hospital personnel who are engaged in planning such programs. This group will include films on anxiety, on psychiatric techniques for the family doctor, and on depression in general practice.

New American films on the vocational rehabilitation of the mentally ill, on day-care centers for the mentally deficient, and on the open hospital are also being considered for the Institute. As in the past, all of the films will take place on Tuesday, Wednesday, and Thursday mornings before the Institute's sessions begin. In addition, there will be afternoon showings on Tuesday and Wednesday from 4:30 to 5:30. Staff members of the Mental Health Materials Center will be available for consultation on the use of mental health films by mental hospital personnel.

JACK NEHER
Mental Health Materials Center

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*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals *33*:61 (June 1) 1959.

BOOK REVIEWS

COMMUNITY AS DOCTOR —by Robert N. Rapoport, Ph.D., Springfield, Ill., Charles C Thomas, 1960, 325 pages, $9.75.

This is a first-hand description and analysis of the pioneering work of Maxwell Jones and his colleagues at Belmont Hospital, England. The author, an anthropologically trained social scientist, spent four years studying the "therapeutic community" created in Belmont's Social Rehabilitation Unit. From this vantage, he presents a clear, coherent review of the Unit's organization, function, and motivating ideology. In his evaluation of the Unit's techniques and effectiveness, Rapoport supplements his own insight with that of such people as Caudill, the Oplers, Stanton and Schwartz, Hollingshead and Redlich, and Leighton, who have been engaged in related studies in the United States. The book is the most comprehensive case study ever printed about social psychiatry in action.

Those interested in applying therapeutic community principles in their hospital units will find this work to be the best guide available. In addition to the specific case presented, a summary chapter lists and discusses some 30 general postulates useful in organizing patient-activities and in relating the patient and his prognosis to the external society.

Rapoport assigns one chapter and considerable emphasis to a conceptual distinction between treatment and rehabilitation. He notes the problems that arise from confusing the two. Treatment has to do with alteration of the personality toward better intrapsychic integration; rehabilitation is concerned with demands of an ongoing social system.

An underlying premise of a treatment frequently assumes that a well-integrated personality will adjust to an ongoing social system, while a premise of rehabilitation frequently assumes that an individual adjusted to the social system has a well-integrated personality. Treatment integrates and rehabilitation adjusts the patient. This is fine, except that the procedures of one often violate those of the other.

The author suggests a clearer separation of patients and procedures into those for treatment and those for rehabilitation. Perhaps, though, we first need to go back and re-examine the relationship between social adjustment and integrated personalities. We need some definitive answers to what sorts of social systems tolerate what levels of intrapsychic integration. Then the clinical conflicts between treatment and rehabilitation might disappear in the face of rephrased problems.

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Maxwell Jones, in the book's introduction, suggests that it would be desirable to use more refined criteria to evaluate the Unit's work. The reader may wish to know more about the follow-up studies of discharged patients. While these shortcomings detract from the book's value, many points of excellence overshadow the deficiencies.

ROBERT E. PACE, M.A.
Winston-Salem, N. C.

MENTAL HEALTH IN THE UNITED STATES: A FIFTY-YEAR HISTORY—by Nina Ridenour, Ph.D., Cambridge, Mass., Harvard University Press, 1961, 140 pages, $3.50.

The 140 pages of this little book are each packed with meaningful phrases which tell a fascinating story in a simple, concise style. As William James said of Clifford Beers' autobiography, "It reads like fiction but is not fiction." The author illustrates her facts by many stories and weaves them all together into an astonishing and enthralling true tale.

The book is a history of the mental health movement in the United States, which has as its theme the development of the National Committee for Mental Hygiene; the committee, born in Connecticut in 1908, is the sturdy ancestor of today's National Association for Mental Health. The leadership, the support, and the patience of this national group were the ingredients that have instigated progress, until today there is a Mental Health Section of the World Health Organization, a World Psychiatric Association, and the U. S. Government's National Institute for Mental Health.

The author, delineating the history of the movement, traces its contributions to the changing concepts of hospital treatment, to the acceptance of psychiatry by the public, and to the changing attitudes of the community toward the mental health movement and toward mentally ill people.

It is an honor to review this excellent book. It will be of interest to everybody, but is particularly recommended to those concerned with mental health programs, whether they are physicians, hospital employees, patients, or their families.

DAVID C. WILSON, M.D.
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1. Fincle, L. P., and Reyna, L. J.: J. Clin. & Exper. Psychopath. 19:7 (Mar.) 1958.

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READERS' FORUM

A HOSPITAL FARM IS WHAT YOU MAKE IT

This is prompted by the article written by Joseph W. Risk in the June 1961 issue of *Mental Hospitals*.

There must be many areas where the setting of the hospital would make a farm operation useless, but our hospital, Columbia

County Hospital in Wyocena, Wisconsin, is in a rural setting. Most of our men patients find it natural to help out on the farm in some way, according to their preference.

Our farm provides milk, meat, eggs, vegetables, berries, and other fruits for 340 mental patients and 76 aged persons in the County Home. The hospital kitchen cans the surplus berries, rhubarb, tomatoes, and cucumbers. We produce Grade A milk for our own consumption.

Our farm manager consults with the cooks to determine what kinds of vegetables we will plant and use. When we have surplus vegetables, the local stores and even local-market gardeners purchase it. Far from competing with local growers, we are helping them.

It seems to me that overcrowded patients' quarters as opposed to roomy pastures should be blamed on the over-all administrative philosophy of the hospital or hospital system. All of our 35 small county hospitals have very adequate food handling facilities, including good mechanical dishwashers. Our sleeping facilities are better than those described in Lynchburg; patients may select their own colors for the dormitories. We also provide cheerful dayrooms, porches, and sitting areas off the wards.

When a man accepts the responsibility of administering a mental hospital, he also accepts the responsibility for putting patient care and welfare above everything else. There is no need to neglect improvements needed for the patients simply because the hospital also operates a farm.

JOHN A. BORUP
Superintendent

PROTECTING THE PSYCHIATRIC CHART

In response to the editor's request for comments on the subject of confidentiality, the psychiatric record is of deep concern to all staff members of the Western Psychiatric Institute and Clinic, Pittsburgh, Pa. Because of this concern, we do not feel that standard forms of permission for release of medical records are applicable to psychiatric records.

The extremely personal nature of the content postulates an obligation upon us to give this chart the maximum protection. Even though the patient may have authorized the release of data, he might not do so at a less stressful stage of his illness. In his existing condition he may not comprehend the depth and meaning of the information he is about to make public.

Lay people seldom have the training needed to interpret psychiatric data. Attorneys and insurance companies often delegate clerical personnel to make copies and/or abstracts of the record. Both professionals and nonprofessionals sometimes take isolated facts out of context, and use them as evidence to prove a point.

We believe that the psychiatric chart should be protected by legislation. Until such legislation is enacted, our Medical Records Committee, in order to protect the patient, directs the medical record librarian to observe the following procedures when she receives requests to examine charts:

1) Authorized staff and students concerned with the care of the patient are permitted to examine the record under stated controlled situations.

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2) Persons who have an authorization from the patient and come to the record department to read the chart are interviewed personally and are furnished with adequate data and an interpretation thereof by the chief of the service or his representative.
3) Legal or professionally authorized requests for photostats of records are referred to the chief of clinic, who will abstract content pertinent to the request. In this way we avoid duplication of a complete record which would then be outside the control of the Medical Records Department.

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References (1) Moss, N. H.; Morrow, B. A.; Long, R. C., and Ravdin, I. S.: J.A.M.A. 140:1336, 1949. (2) Niemiro, B. J.: Journal-Lancet 71:364, 1951. (3) Combes, F. C.; Zuckerman, R., and Kern, A. B.: New York J. Med. 52:1025, 1952. (4) Lowry, K. F.: Postgrad. Med. 11:523, 1952. (5) Diamond, O. K.: New York J. Med. 59:1792, 1959.

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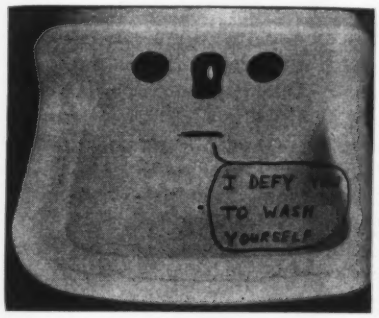
RELUCTANT WASHBASIN

Recently, through our Volunteer Department, Mrs. Lila P. Worth from the Louisville Photographic Society visited Central State Hospital, Lakeland, Kentucky, and took many pictures for us. In flipping through these, my eyes were arrested by the rather formidable looking creature in the enclosed photograph.



It is located on our ladies' admission ward where one would normally expect to find a wash basin. If you are a real strong lady and able to jab its eyes hard enough, water comes out through the nose. Of course, you can't wash yourself during this procedure because one hand, or generally both, has to be jammed into the eye to get the water to flow. This usually means that you work on the cold for a while and then on the hot. All the time you are filling the thing, it's slowly draining through that tiny hole in the bottom, so usually all you have to show for your exhausting work are a few rings of sediment which are difficult to rinse away because the little hole doesn't carry off water fast enough for effective rinsing—acting for all the world like a somewhat balky household drain.

I would really like to know what right we have to inflict such strange instruments as these on people who are already sick and away from their loved ones and those things which they hold dear and familiar. I am told that these devices do not require much maintenance, but I wonder where our first duty lies—whether we should be striving for a maintenance-free

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WALTER FOX, M.D.
Superintendent

CURRENT STUDIES

This column lists investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available. Requests should be sent to them directly, with 25¢ for postage and handling.

AFTERCARE FOR DISCHARGED MENTAL PATIENTS

A document of unusual interest is a report on a five-state study of intensive aftercare of discharged mental patients, to determine whether such programs are medically and economically sound. Spencer M. Free, Ph.D., Science Information Department, and David F. Dodd, M.B.A., Mental Health Education Unit, Smith, Kline & French Laboratories, were the compilers.

The study involved more than 600 patients from Colorado, Kentucky, Michigan, Pennsylvania, and Virginia, and the results were discussed at a conference in Philadelphia in May 1960.

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News and Notes

President Outlines Purposes of New World Organization

The General Assembly of the World Psychiatric Association will hold a special meeting in its headquarters city, Geneva, Switzerland, in July 1962, announces Dr. D. Ewen Cameron, first president of the newly created international association. The General Assembly, which is composed of representatives from all member psychiatric organizations, will consider the association's constitution and development.

"The general purpose of the Association is to give expression at the world level to the extraordinarily rapid growth of psychiatry," says Dr. Cameron. "Every country represented at the Third World Congress of Psychiatry (during which the new organization was established in June 1961) brought reports of exceptional expansion of psychiatric facilities—the building of clinics and hospitals, the setting up of research, the training of personnel, the organization of programs for public education and the prevention of mental illness. This was true alike of countries in which psychiatric facilities had been long established and in countries which have gained their independence only within the last decade and are now starting to organize health facilities on a national basis.

"The World Psychiatric Association will represent psychiatry to other international organizations such as the World Health Organization; the United Nations Educational, Scientific, and Cultural Organization; and the general and special world medical associations.

"The Association will open up avenues for communication and consultation between psychiatric organizations and individuals in the various countries, and will serve to define and strengthen standards for training and research."

Other officers of the World Psychiatric Association are Dr. Francis J. Braceland, vice-president; Dr. Henri Ey, general secretary; Dr. William Sargant and Dr. J. Lopez-Ibor, assistant secretaries; and Dr. P. Sivadon, treasurer. In addition, three North American psychiatrists were elected by the General Assembly to the Permanent Council: Drs. Winfred Overholser,

Mental Hospitals Reprint Service

Readers frequently request reprints of articles in *Mental Hospitals* for distribution to others for various educational and informational purposes. The price list and order form below have been devised to simplify the procedure for obtaining reprints. Since it is not economical to reprint less than 100 copies, the minimum price is based on that number. Reprints are exactly the same size as the originals in the magazine and take the same number of pages. Prices quoted include handling and shipping costs. *Please enclose a check or money order for the exact amount with your order.* Delivery will take approximately three weeks.

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QUARTERLY CALENDAR

APA ANNUAL MEETINGS

1962 May 7-11, Royal Oak Hotel, Toronto, Canada (118th)
1963 May 6-10, Chase-Park Plaza Hotel, St. Louis, Mo. (119th)

APA MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Sheraton-Fontenelle Hotel, Omaha, Neb. (13th)
1962 Sept. 24-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel to be announced, Boston, Mass. (16th)

OTHER APA MEETINGS

Committee Meetings, November 3-4, Marriot Motor Hotel, Washington, D. C.
Council Meeting, November 24-25, APA Central Office, Washington, D. C.
Divisional Meeting, September 21-23, Hotel Utah, Salt Lake City
Divisional Meeting, November 10-12, Hotel New Yorker, New York, N. Y.
Divisional Meeting, November 16-18, Schroeder Hotel, Milwaukee, Wis.

CANADIAN MENTAL HEALTH SERVICES INSTITUTE

1962 January 15-18, Chateau Laurier Hotel, Ottawa, Ontario (2nd) (Inq. Dr. V. E. Chase, Canadian Psychiatric Assn., Suite 103, 225 Lisgar St., Ottawa 4, Ontario)

OTHER PROFESSIONAL MEETINGS

AMERICAN HOSPITAL ASSOCIATION,, Annual Meeting, *September 25-28,* Atlantic City, N. J.

CANADIAN ASSOCIATION FOR RETARDED CHILDREN, Annual Meeting, *September 26-28,* Hotel Vancouver, Vancouver , B. C.

NATIONAL REHABILITATION ASSOCIATION, National Conference, *October 2-4,* Whitcomb Motor Hotel, San Francisco, Cal.

AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY, Examinations for certification in P&N, *October 9-11,* Chicago, Ill. (Inq. Dr. D. A. Boyd., Exec. Sec., 102-110 2nd Ave, S. W., Rochester, Minn.)

INTERNATIONAL SYMPOSIUM ON NEUROLOGICAL INVESTIGATIONS, *October 9-10,* Mexico City (Inq. Dr. Manuel Velasco-Suarez, Tonala no. 15, Mexico 7, D. F., Mex.)

NATIONAL ASSOCIATION FOR RETARDED CHILDREN, Annual Convention, *October 9-15,* Sheraton-Palace Hotel, Chicago, Ill.

ACADEMY OF PSYCHOSOMATIC MEDICINE, Annual Meeting, *October 12-14,* Emerson Hotel, Baltimore, Md. (Inq. Dr. G. Sutherland, Chm., 3700 N. Charles St., Baltimore, Md.)

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, Fall Meeting, *October 16,* Omaha, Neb. (Inq. Dr. H. McPheeters, 620 S. 3rd St., Louisville, Ky.)

AMERICAN SOCIETY OF MENTAL HOSPITAL BUSINESS ADMINISTRATORS, Annual Meeting, *October 16,* Omaha, Neb. (Inq. Dr. H. McPheeters, 620 S. 3rd *15-16,* Hotel Fontenelle, Omaha, Neb.

ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOTHERAPY, 2nd Emil A. Gutheil Memorial Conference, *October 29,* Barbizon Plaza Hotel, New York, N. Y.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Annual Meeting, *November 5-11,* Sheraton-Cadillac Hotel, Detroit, Mich.

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Fall Meeting, *November 9-12,* Hotel Berkeley Carteret, Asbury Park, N. J.

GERONTOLOGICAL SOCIETY, Annual Meeting, *November 9-11,* Penn Sheraton Hotel, Pittsburgh, Pa.

AMERICAN PUBLIC HEALTH ASSOCIATION, Annual Meeting, *November 13-17,* Cobo Hall, Detroit, Mich.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, Annual Meeting, *November 16-18,* Miami, Fla.

Daniel Blain, and Robert H. Felix. The Permanent Council consists of 25 members; the officers of the Associations are ex-officio members. The North American psychiatrists were appointed as individuals and do not represent the APA.

Institute Program Completed

The program for the 13th Mental Hospital Institute to be held October 16 through 19 at the Sheraton-Fontenelle Hotel, Omaha, Nebraska, is nearing completion.

Mr. Andrew Brown, director of Community Services for the United Auto Workers of Detroit, has accepted the invitation of the Program Committee to be the labor representative on the Thursday afternoon plenary panel discussion on "Federal-State Relations—Formulae for Sharing Costs." The panel, to be moderated by Dr. Mathew Ross, also includes Dr. Daniel Blain, Dr. Irving J. Cohen, Mr. Sidney Spector, Dr. Paul Hoch, and Ralph Robey, Ph.D., economic advisor to the National Association of Manufacturers.

The Academic Lecture will be delivered by Dr. R. A. Cleghorn, associate professor of psychiatry at McGill University. The title of Dr. Cleghorn's paper will be "The Expanding Vista in Psychiatric Research and Thought."

California Modernizes Hospital Records

The California State Purchasing Division recently placed an order with Addressing Machine Co. of San Francisco to manufacture 593 address-plate-imprinting machines, modified specifically for state hospital use.

According to Daniel Blain, M.D., director of the Department of Mental Hygiene, the machines will be used in state hospital wards to print patients' names, case numbers, birth dates, and related data on record forms as required. The plan is similar to that used on credit cards in service stations and stores.

R. Bruce Jordan, management analyst for the department, ex-

plained that the machines will speed up and increase efficiency in the processing of medical records and will streamline paper work in the hospitals.

PEOPLE and PLACES

OHIO: **Joseph A. Mendelson, M.D.,** superintendent, Dayton State and Receiving Hospital, Dayton, has retired and has been succeeded by **M. T. Faruki, M.D.,** formerly the assistant superintendent.

Sagamore Hills Children's Psychiatric Hospital near Cleveland opened in June. **Gordon R. Loomis, M.D.,** is superintendent of the new 92-bed facility.

OKLAHOMA: **Mrs. Anna Scruggs,** superintendent of Enid State School retired on August 15. Albert Shafter, Ph.D., succeeds her.

Robert E. Ashley, M.D., resigned as superintendent of Central State Griffin Memorial Hospital. **Glyne Williams,** State Commissioner of Mental Health, is acting superintendent.

SOUTH CAROLINA: **M. G. Morehouse, M.D.,** has been appointed director of the York-Chester-Lancaster County Mental Health Center at Rock Hill. Dr. Morehouse was formerly a staff psychiatrist at the South Carolina State Hospital in Columbia.

Russell Ramsey Mellette, M.D., has been appointed as director of the Charleston County Mental Health Clinic. Dr. Mellette succeeds **W. C. Miller, M. D.,** who has resigned to accept a position on the staff of the South Carolina Medical College.

HERE & THERE: **Peter A. Peffer, M.D.,** superintendent and medical director, Glenwood State School, Glenwood, Iowa, has announced his resignation effective September 5. Dr. Peffer will become superintendent of Paul A. Dever School at Taunton, Mass. **Richard C. Cooke, M.D.,** superintendent of Dever School since 1951, will retire.

Thomas L. Nelson, M.D., superintendent and medical director of Sonoma State Hospital, Elridge, Cal., will resign in November. He has accepted an associate professorship in pediatrics at the University of Kentucky.

Fred M. Kramer, M.D., has been named psychiatrist in charge of the newly opened outpatient psychiatric clinic at Meriden Hospital in Meriden, Conn. Dr. Kramer has been in private practice in Meriden and on the staff of the Meriden Child Guidance Clinic since 1960. **Mrs. Charlotte S. Connor** has been appointed chief psychiatric social worker at the hospital. Mrs. Connor was formerly executive secretary of the Family Service Association in Meriden.

Harrison M. Baker, M.D., director of correctional psychiatry at the State Hospital, Concord, N. H., has resigned to enter private practice in Phoenix, Ariz.

Douglas F. Powers, M.D., professor of child psychiatry at Vanderbilt University, Nashville, Tenn., has been appointed director of the **Virginia Treatment Center for Children,** which will open early this fall in Richmond.

Donald B. Crider, M.D., has resigned as director of the Valley Mental Health Center, Staunton, Va., to accept an appointment as director, Blair County Mental Health Center in Altoona, Pa.

Theodore C. Dilworth, special education administrator, N. J. State Department of Education, has been named chief of educational services at The Training School, Vineland, N. J.

A 36-bed psychiatric unit was opened recently at Sinai Hospital in Detroit, Mich. **Norman Rosenzweig, M.D.,** is director of the unit. Prior to assuming his position at Sinai Hospital, Dr. Rosenzweig was assistant professor of psychiatry at the University of Michigan.

DEATH: **Samuel Cohen, M.D.,** former medical director of the Philadelphia Psychiatric Hospital, Pa., died July 1.

INDEX TO ADVERTISING **SEPTEMBER 1961**

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